

PROPOSALS TO EXPAND COVERAGE OF MENTAL  
HEALTH UNDER MEDICARE-MEDICAID

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HEARING  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON FINANCE  
NINETY-FIFTH CONGRESS  
SECOND SESSION

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AUGUST 18, 1978

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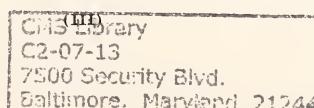
## CONTENTS

### PUBLIC WITNESSES

	Page
American Nursing Association, Martha Mitchell, chairperson, division on psychiatric and mental health nursing, and assistant professor of psychiatric nursing, Yale University School of Nursing; accompanied by Pat Burrell, on behalf of American Nursing Association-----	3
American Psychiatry Association, James Cavanaugh, M.D., clinical director, department of psychiatry, Rush-Presbyterian-St. Lukes Medical Center, Chicago, Ill., and Roy Menninger Foundation, Topeka, Kans-----	53
American Psychological Association, Nicholas A. Cummings, Ph. D., president-elect, accompanied by Russell Bent, Ph. D., president, Georgia Psychological Association; Joan Willens, Ph. D., chair, psychology advisory committee, Colorado Medicare Study, and Clarence J. Martin, executive director and general counsel, Association for the Advancement of Psychology-----	33
Brandt, Sanford F., vice president, fundraising, Mental Health Association-----	8
Cavanaugh, James, M.D., clinical director, department of psychiatry, Rush-Presbyterian-St. Lukes Medical Center, Chicago, Ill., and Roy Menninger, M.D., president, the Menninger Foundation, Topeka, Kans., on behalf of the American Psychiatric Association-----	53
Cranston, Hon. Alan, a U.S. Senator from the State of California-----	32
Cummings, Nicholas A., Ph. D., president-elect, American Psychological Association, accompanied by Russell Bent, Ph. D., president, Georgia Psychological Association; Joan Willens, Ph. D., chair, psychology advisory committee, Colorado Medicare Study, and Clarence J. Martin, executive director and general counsel, Association for the Advancement of Psychology-----	33
Gross, Martin L., author of "The Psychological Society"-----	15
Klein, Donald F., M.C., director of research, New York State Psychiatric Institute-----	44
Mental Health Association, Sanford F. Brandt, vice president, fundraising-----	8
Mitchell, Martha, chairperson, division on psychiatric and mental health nursing, of the American Nursing Association, and assistant professor of psychiatric nursing, Yale University School of Nursing; accompanied by Pat Burrell, on behalf of American Nurses Association, Inc-----	3
National Council of Community Mental Health Centers, G. Kinsey Stewart, Ph. D., president, board of directors, and John Wolfe, Ph. D., executive director-----	67
Stewart, G. Kinsey, Ph. D., president, board of directors, and John Wolfe, Ph. D., executive director, National Council of Community Mental Health Centers -----	67

### COMMUNICATIONS

Allan Moltzen, national chair, committee on legislation and services, Mental Health Association-----	112
American Federation of State, County and Municipal Employees, AFL-CIO-----	107
American Medical Association, James H. Sammons, M.D-----	106
DeSantis, Peter, executive director, North Central Health Care Facilities-----	104
Gerontological Society, Bennett Gurian, M.D., member, information committee -----	105



Gurian, Bennett, M.D., member, information committee, Gerontological Society -----	105
Mental Health Association, Allan Moltzen, national chair, committee on legislation and services-----	112
National Association of Private Psychiatric Hospitals, Joy Midman, associate director-----	111
Ross, E. Clarke, director, Government Activities Office, United Cerebral Palsy Associations, Inc -----	97
Sammons, James H., M.D., American Medical Association-----	106
Taylor, Michael A., M.D., professor and chairman, University of Health Sciences/the Chicago Medical School-----	106
United Cerebral Palsy Associations, Inc., E. Clarke Ross, director, UCPA Government Activities Office-----	97

#### ADDITIONAL INFORMATION

Committee press release-----	1
American Psychiatric Association, Jay B. Cutler, special counsel and director, Government relations-----	57
Program Evaluation Summary: NIMH Community Programs, by J. Richard Woy, Ph. D-----	79
Statement of Senator Dole and list he referred to-----	93
Prepared statements of:	
Senator Daniel K. Inouye-----	94
Senator Spark Matsunaga-----	95

# PROPOSALS TO EXPAND COVERAGE OF MENTAL HEALTH UNDER MEDICARE-MEDICAID

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FRIDAY, AUGUST 18, 1978

U.S. SENATE,  
SUBCOMMITTEE ON HEALTH OF  
THE COMMITTEE ON FINANCE,  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 9:30 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Long, Matsunaga, Dole, Laxalt, and Danforth.

[The committee press release announcing this hearing follows:]

## SUBCOMMITTEE ON HEALTH ANNOUNCES HEARINGS ON MENTAL HEALTH SERVICES UNDER MEDICARE AND MEDICAID

The Honorable Herman E. Talmadge, chairman of the Subcommittee on Health of the Committee on Finance, announced today that the subcommittee will hold a hearing on mental health services under medicare and medicaid.

Legislation to expand present coverage of mental health services has been introduced by Senators Inouye and Matsunaga of Hawaii, among others.

The hearing will begin at 9:00 a.m., Friday, August 18, 1978, in room 2221 of the Dirksen Senate Office Building.

The subcommittee expects to hear testimony from: Martin Gross, author of The Psychological Society; the Administration; the American Nurses Association; the American Psychiatric Association; the American Psychological Association; the Mental Health Association; and the National Association of Community Mental Health Centers.

## LEGISLATIVE REORGANIZATION ACT

The Legislative Reorganization Act of 1946 requires all witnesses appearing before the Committees of Congress to "file in advance written statements of their proposed testimony and to limit their oral presentations to brief summaries of their argument." In light of this statute, and the limited time available for the hearing, witnesses scheduled to testify must comply with the following rules:

1. A copy of the written statement must be filed by noon the day before the witness is scheduled to testify.
2. All witnesses must include with their written statements a summary of the principal points included in the statement.
3. The written statements must be typed on letter-size paper (not legal size) and at least 75 copies must be submitted before the beginning of the hearings.
4. Witnesses are not to read their written statements to the Subcommittee, but are to confine their 10-minute oral presentations to a summary of the points included in the statement.
5. No more than 10 minutes will be allowed for the oral summary.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

*Written statements.*—Persons not scheduled to make an oral presentation and others who wish to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearings. These written statements should be submitted to Michael Stern, staff director, Senate Committee on Finance, room 2227, Dirksen Senate Office Building, Washington, D.C., not later than Friday, September 1, 1978.

Senator TALMADGE. This hearing will be in order.

This morning, we will receive testimony of an extremely important aspect of health care; namely, the diagnosis and treatment of mental illness.

Coverage of mental care under the medicare and medicaid programs is essentially limited. However, there are significant and continuing pressures for expansion of that coverage.

In good part, that pressure is not just in terms of medicare and medicaid, but obviously as a means of establishing a precedent for coverage under any national health insurance program which might be enacted in the future.

There is no question but that Congress is willing to provide proper coverage for necessary mental care.

The question to which we hope to get some answers today is—what is proper mental care?

To what extent would Congress be inviting erroneous and costly new expansion in areas where, in large part, an individual practitioner can define an almost infinite need for care.

This is an area where there are often no objective parameters. We have limited resources available for health care financing. We need to be careful in how we allocate those resources.

To that end, as part of Public Law 95-210, a section propounding a series of specific questions to be answered by the Department of HEW with respect to mental care services was included.

Unfortunately, while the law required that report to be submitted to the Congress no later than June 16 of this year, it has still not been received. We look forward to receiving that report at some time.

That information, along with the testimony today, should be helpful to the committee in its efforts to do what is right and to avoid what is wrong.

The testimony and report should help us to encourage and support demonstrated and proven practices in mental care.

It should help us avoid encouraging and nurturing fads, as well as questionable and marginal methods of diagnosis and treatment.

We look forward to hearing from our witnesses this morning. We will also be privileged to have Senator Inouye of Hawaii join us.

Senator Inouye has had longstanding interest in the betterment and care of the mentally ill. It will be a pleasure to have him with us.

The first witness this morning will be Martha Mitchell of the American Nurses' Association.

We are delighted to have you, and you may proceed, and unfortunately, we must impose a time limitation of 10 minutes.

**STATEMENT OF MARTHA MITCHELL, CHAIRPERSON, DIVISION ON PSYCHIATRIC AND MENTAL HEALTH NURSING, AND ASSISTANT PROFESSOR OF PSYCHIATRIC NURSING, YALE UNIVERSITY SCHOOL OF NURSING; ACCCOMPANIED BY PAT BURRELL, ON BEHALF OF AMERICAN NURSES ASSOCIATION, INC.**

**Ms. MITCHELL.** I am Martha Mitchell, chairperson of the division on psychiatric and mental health and nursing practices of the American Nursing Association, and in the past year was a member of the President's Commission on Mental Health. With me is Patricia Burrell, from Honolulu, Hawaii, a psychiatric mental health nurse, certified by the American Nurses Association, and also Constance Holleran of the ANA's Washington office.

In line with the time pressures of the committee, I will highlight our statement and ask that the full statement appear in the record.

We appreciate this opportunity to appear before you today to speak in favor of full reimbursement for mental health services provided to those persons covered by medicare and medicaid. Such reimbursement should be available regardless of the setting in which that care is provided, or the discipline of the mental health practitioner providing that service.

Current law severely restricts not only the types of professionals providing psychiatric care, but also the settings in which such care is delivered. Direct reimbursement for psychiatric services under medicare and medicaid is available only to physicians and to institutions providing such care.

Generally, other mental health professionals are not directly reimbursed. Further, medicare law specifies a 190-day lifetime limit on inpatient psychiatric hospital services. This seems like an arbitrary number.

For outpatient mental health services, medicare and medicaid imposes a \$250 annual limit on reimbursement per patient. This figure is unrealistically low, especially when compared with coverage under medicare and medicaid for outpatient care of somatic illnesses.

The question of reimbursement for mental health services was one of the issues considered by the President's Commission on Mental Health. Its report, issued last April, concluded that—

What we need is a more comprehensive and coordinated public and private strategy for financing mental health service where payment is based upon the need for care, not diagnosis, and upon the appropriateness of care, not the discipline of the provider.

This sums up very well our position in regard to reimbursement for mental health services, that a variety of skills can be utilized to advantage. Many of the problems in mental health care and in health care in general, including skyrocketing costs, are compounded by, if not directly traceable to, the current reimbursement system which is based on institutionalization and physician services rather than on the needs of the patient.

We believe, however, that prospects were never brighter than they are presently for changes which will permit more appropriate utilization of the nursing role in delivery of mental health services.

An indication of the change that is taking place lies in the action of farsighted legislators such as Senator Inouye who has introduced bills to provide for reimbursement under medicare and medicaid for nursing services. One of these measures, S. 233, is cosponsored by Senator Matsunaga. It specifically seeks to expand utilization of the professional services of qualified psychiatric nurses under the medicare and medicaid programs. We fully support that bill as it was introduced.

Still another sign is language included in the House-Senate Appropriations conference report on the Defense Department fiscal year 1978 appropriation. It allows psychiatric nursing and nurse midwife services as permissible reimbursements under the civilian health and medical program of the uniformed services.

Psychiatric nursing is directed toward health maintenance as well as corrective measures for mental disorders. It is practiced in a wide variety of settings, ranging from institutions which are characterized by high-level teamwork and technology to community-based non-institutional settings where nurses practice on a highly independent, self-directed basis.

In the role of primary care provider, nurses assume responsibility for continuous care for individuals and families beginning at the point of the clients' entry into the mental health delivery system and extending through the treatment and rehabilitative phase.

Major direct nursing care functions include: screening and evaluation; individual, family, and group psychotherapy; home visits; establishing a therapeutic milieu in institutional contexts; health teaching; providing support and medication surveillance, especially for long-term patients; and responding to clients' needs through community action, if that is appropriate.

The problem of access to mental health services under current reimbursement policies is particularly acute among the chronically underserved groups, namely, the minorities, low-income women, people in rural areas, children and adolescents, and most especially the older.

Older people, disproportionately poor, ill, and underserved, exemplify a population with whom nursing is already deeply involved and concerned, and who would be helped by having mental health services available as a covered benefit. Current narrow, in-patient focused, coverage leaves many older people not only underserved, but inappropriately served.

One of the chief obstacles to the proper utilization of nurses in the mental health field has been reimbursement policies which denied payments for nursing services. The President's Commission on Mental Health, which directed specific attention to underserved segments of our population, specifically included mental health nursing services among those which should be reimbursable.

Home care provided by psychiatric nurses has been found to be very effective and can be provided at considerably lower cost than if the patient is hospitalized, but often this is thwarted because medicare and other third-party payors do not recognize the nurse as an appropriate provider of reimbursable services.

Many nurses are well-qualified to go into private psychiatric nursing practice, and often can provide service to those who otherwise would be unable to have access to such care.

In 1976, the American Nursing Association worked together with six national organizations concerned with mental health, to develop a position statement identifying principles for the inclusion of mental health benefits in a national health insurance plan.

They concluded that, No. 1—

National health insurance should provide benefits which promote an integrated and coordinated system of mental health service delivery that assures easy access and continuity of care.

And it pointed out that—

Present concepts of reimbursement tend to emphasize the setting rather than specific service provided to a patient. The treatment provided to a patient rather than the setting should be the more important determinant of reimbursement.

We believe that if reimbursement were based on services and were provided to patients rather than setting or who provides the services—so long as the provider is a qualified mental health practitioner—that mental health services in this country will be improved, be more widely available to those in need of such care and more cost-effective than under the present system. That is our goal, and we hope, that of the policymakers.

Senator TALMADGE. Thank you very much for an excellent statement.

Senator Long?

Senator LONG. I heartily agree with your statement and I think it deserves a great deal of consideration by the committee.

Senator TALMADGE. Senator Matsunaga?

Senator MATSUNAGA. I, too, wish to join in commending you for your excellent statement.

I have one question. What type of additional training does the psychiatric nurse undertake in order to qualify for independent treatment of a patient?

Ms. MITCHELL. Senator, the Psychiatric Mental Health Nursing Specialist, who is the nurse that we seek to have recognized as a qualified provider under medicare and medicaid, achieves a masters degree or higher, but a master's degree in psychiatric mental health nursing or a closely related field. And, in addition to that, is certified in order to be reimbursable and would also have post master's experience under supervision.

Senator MATSUNAGA. Thank you very much.

Senator TALMADGE. Thank you very much.

[The prepared statement of Ms. Mitchell follows:]

STATEMENT OF THE AMERICAN NURSES' ASSOCIATION BY MS. MARTHA MITCHELL  
AND MS. PAT BURRELL

We appreciate the opportunity to appear before you today to speak in favor of full reimbursement for mental health services provided to those persons covered by Medicare and Medicaid. Such reimbursement should be available regardless of the setting in which that care is provided or the discipline of the mental health practitioner providing that service.

Current law severely restricts not only the types of professionals providing psychiatric care but also the settings in which such care is delivered. Direct reimbursement for psychiatric services under Medicare and Medicaid is available only to physicians and to institutions providing such care. Generally, other mental health professionals are not directly reimbursed. Further, Medicare law specifies a 190-day lifetime limit on inpatient psychiatric hospital services. This seems like an arbitrary number which could severely restrict a patient's

progress. Only a trained mental health professional can accurately determine the number of days of hospitalization a patient requires. For outpatient mental health services, Medicare and Medicaid imposes a \$250 annual limit on reimbursement per patient. This figure is unrealistically low, especially when compared with Medicare and Medicaid reimbursement limits for outpatient care of somatic illnesses.

The question of reimbursement for mental health services was one of the issues considered by the President's Commission on Mental Health. Its report, issued earlier this year, concluded that:

"What we need is a more comprehensive and coordinated public and private strategy for financing mental health service where payment is based upon the need for care, not diagnosis, and upon the appropriateness of care, not the discipline of the provider."

This sums up very well our position in regard to reimbursement for mental health services: that a variety of skills can be utilized to advantage. Many of the problems in mental health care and in health care in general, including skyrocketing costs, are compounded by, if not directly traceable to, the current reimbursement system which is based on institutionalization and physician services rather than on the needs of the patient.

Commenting on the availability of mental health care in this country, the President's Commission report states: "Many who need mental health care cannot afford the help they require. It is pointless to design, plan, and provide service systems if people do not have the means to pay for them. It is short-sighted to devise financing mechanisms that promote more restrictive and expensive forms of treatment when other less expensive options would be as effective. It is wasteful to invest money in establishing programs through project grants and then deprive the programs of access to third-party reimbursement funds to support their services once the grants are ended."

We agree with this analysis. We also believe that prospects were never brighter than they are today for changes which will permit more appropriate utilization of the nursing role in delivery of mental health care services. One of the chief obstacles to the proper utilization of nurses in the mental health field has been reimbursement policies which deny payment for nursing services.

An indication of the change that is taking place lies in the action of far-sighted legislators such as Senator Inouye who has introduced bills to provide for reimbursement under Medicare and Medicaid for nursing services. One of these measures, S. 233, which is cosponsored by Senator Matsunaga, specifically seeks to expand utilization of the professional services of qualified psychiatric nurses under Medicare and Medicaid programs. We fully support that bill as it was introduced.

Still another sign is language included in the House-Senate Appropriations conference in its report on the Defense Department fiscal year 1978 appropriations. It allows psychiatric nursing and nurse midwife services as permissible reimbursements under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

The number of well-prepared psychiatric mental health nurses has been increasing rapidly in recent years, yet practice by these nurses has been severely inhibited by reimbursement policies. Clinics that cannot get reimbursement for the services provided by the psychiatric nurse do not, of course, continue to employ such nurses.

Psychiatric nursing is defined by the Division of Psychiatric and Mental Health Nursing of the American Nurses' Association, as a specialized area of nursing practice, utilizing theories of human behavior as its science, and purposeful use of self as its art. Psychiatric nursing is directed toward health maintenance as well as corrective measures for mental disorders. It is practiced in a variety of settings, from institutions characterized by high levels of teamwork and technology to community-based, non-institutional settings where the nurse practices on a highly independent, self-directed basis. In the role of primary care provider, they assume responsibility for continuous care for individuals and families beginning at the point of the clients' entry into the mental health delivery system and extending through the treatment and rehabilitation phase.

Direct nursing care functions include individual and group psychotherapy, family therapy, screening and evaluation, making home visits, establishing a therapeutic milieu, conducting health teaching activities, providing support and medication surveillance and responding to clients' needs through community action, if that is appropriate.

Ease of access to health care is controlled by several factors. Most pertinent are physical access (including flexibility in the scheduling at the convenience of the client) as well as the actual location of these services, and financial access permitted by the system. Insurance defines both physical and financial access to the provider. If reimbursement for services is limited to one group of health professionals, this obviously limits the physical access by excluding other health professionals, such as nurses, who can and do provide services in a variety of settings—schools, neighborhood health centers, public health departments, and the home. Equally important is the limited access to the full range of services which nursing can provide.

The problem of access to mental health services under current reimbursement policies is particularly acute among the chronically underserved: the minorities, low-income women, people in rural areas, children and adolescents, the dying and most especially the aged.

Older people, disproportionately poor, ill and underserved, exemplify a population with whom nursing is already deeply involved and concerned, and who would be helped by having mental health services available as a covered benefit. Current narrow, in-patient focused, coverage leaves many older people not only underserved, but inappropriately served.

As the President's Commission on Mental Health suggests, that with the current Medicare coverage "... often the only option for diagnosing the problems of or treating the elderly with mental disability is to hospitalize them." In this case, limited medical insurance defines treatment, narrows options, and inhibits the full range of professional services needed.

The President's Commission on Mental Health, which directed particular attention to underserved segments of our population, specifically included psychiatric mental health nursing among services which should be reimbursable, stating that, "All covered services must be rendered by, or be under the direct clinical supervision of a physician, psychologist, social worker, or nurse with an earned doctorate or master's degree and with the appropriate clinical competence as established by state licensure or certification by a national body."

Another example of problems created by current reimbursement mechanisms involved a patient in a therapy group by psychiatric nurses who suddenly discovered that his new insurance carrier would not cover his treatment unless it was provided by a psychiatrist. He was faced with the disrupting decision of whether to stay and try to pay the fees himself or leave and attempt to get into another group, probably extending his time in therapy.

Home care provided by psychiatric nurses has been found to be effective and can be provided at considerably lower cost than if the patient is hospitalized. But often this is thwarted because Medicare and other third-party payors do not recognize the nurse psychotherapist as an appropriate provider of reimbursable services.

Many nurses are well qualified to go into private psychiatric nursing practice and often can provide service to those who otherwise would be unable to have such care. For example, psychiatric mental health nursing specialists, in a group practice in rural Winona, Minn., greatly enhance the availability of mental health services to the neighboring population. Working in planned periodic collaboration with an urban-dwelling psychiatrist some 40 miles away, these specialists provide quality mental health care to a number of people who under other circumstances would remain isolated and underserved.

One of the authors of an article in "The Michigan Nurse" had developed a treatment program for autistic children and their families. Following her experience with an agency that treated autistic children and the completion of master's degrees in child psychiatric nursing, she instituted a family-oriented, out-patient treatment program which included behavioral management techniques and family teaching and counseling. She is associated with a physician who does the initial client evaluations and follows the clients' medical regimen: the nurse independently develops, implements, and monitors the psychotherapeutic treatment program for the client and family.

In 1976, the American Nurses' Association, along with six national organizations concerned with mental health, convened a panel to develop a common position statement identifying principles for the inclusion of mental health benefits in a national health insurance plan.

Among its conclusions was that "national health insurance should provide benefits which promote an integrated and coordinated system of mental health

service delivery that assures easy access and continuity of care." And it pointed out that "present concepts of reimbursement tend to emphasize the setting rather than specific service provided to a patient. The treatment provided to a patient rather than the setting should be the more important determinant of reimbursement."

That statement lists the kinds of mental health services that should be available under National Health Insurance and recommends that "such services should be reimbursed as long as they can be documented as an integral part of a specific treatment plan and are provided by or under the supervision of a qualified mental health practitioner."

We believe that if reimbursement were based on services provided to patients rather than settings or who provides the services (so long as the provider is a qualified mental health practitioner) that mental health services in this country will be improved, be more widely available to those in need of such care and more cost effective than under the present system. That is our goal and we hope, that of the policymakers.

Senator TALMADGE. The next witness is Mr. Sandford F. Brandt, vice president, fundraising, Mental Health Association.

Mr. Brandt, you may insert your full statement in the record and summarize it in 10 minutes or less, if you will.

Mr. BRANDT. Thank you, Mr. Chairman.

#### **STATEMENT OF SANDFORD F. BRANDT, VICE PRESIDENT, FUND-RAISING, MENTAL HEALTH ASSOCIATION**

Mr. BRANDT. My name is Sandford F. Brandt. I live in Norris, Tenn. I am a past president of the Tennessee Mental Health Association and currently a member of the board of the National Association. I am one of the vice presidents.

I have been a volunteer in mental health for, I would say, about 20-some years at the local, State, and national levels. I have submitted a prepared testimony and will summarize it here. First, however, I do wish to correct one typographical error in the prepared testimony.

At the top of page No. 3, at the second line, I refer to Public Law 95-250. That should be Public Law 95-210, the same public law the chairman referred to a moment ago.

Now, the essence of our testimony is that both medicare and medicaid discriminate against the mentally ill and that discrimination is unfair, unwarranted, and should be ended.

Medicare discriminates directly in three ways. Part A, there is a 190-day lifetime limit on the coverage in psychiatric hospitals. No such limit exists on coverage in any other hospitals. We recommend elimination of that limitation so that the benefits for a person in a psychiatric hospital, would be the same as for those persons in other hospitals, regardless of the diagnosis.

Under part B, the optional insurance, the reimbursement, if the diagnosis is mental illness, is only 50 percent after the deductible. This is compared to 80 percent for all other covered illnesses. We believe that is discriminatory and the reimbursement for a patient diagnosed as mentally ill should be the same 80 percent as for any other covered illness.

Also, in that same section of part B, there is a \$250 annual ceiling on reimbursement for mental illness. If the deductible is also for mental illness, the ceiling is \$202. There is no ceiling on any other covered illness that I know of in medicare.

We would like to see the ceiling removed. However, the President's Commission on Mental Health in its report released on April 27 recommended increasing the ceiling from \$250 to \$750 and at this point in time, we subscribe to that \$750 limit.

Incidentally, all of our recommendations are consistent with those on the President's Commission's report—or vice versa, all of their recommendations are consistent with ours, whichever came first.

Now, medicare discriminates against the mentally ill indirectly in that it does not recognize community mental health centers as providers, and we urge this committee to report out an amendment granting provider status to CMHC's. Now, this was done last year in Public Law 95-210 in the case of rural health clinics, and we would like to see the same provision for community mental health centers.

I am pleased to note that just 2 days ago the House Ways and Means Committee approved a bill that goes a great step in this direction. It recognizes federally funded community centers as direct providers for up to 10 outpatient visits and up to 60 partial hospitalization days, provided that there is utilization review someplace along the way.

Unfortunately, this amendment, however pleased we are that it is in the bill, does not go far enough. First, it does nothing for those medicare subscribers who choose private practitioners. They are still bound by the existing law.

It does nothing for those medicare subscribers who live in areas that are not served by community mental health centers. Now that is most of the country. Of the 1,500 areas, there are about 700 which have CMHC's.

So we would like to go beyond what is in the House bill. However, let me say that if this committee in its wisdom would go along with the House version, we certainly are not going to object.

Now, medicaid in title XIX discriminates in several ways. We are confining our remarks at this time to one glaring instance as it occurs in the early and periodic screening, diagnostic and treatment program. The provision in section 1912(b)(1) authorizes States to deny treatment to children who, under this very program, have been diagnosed as mentally ill. It is all right to diagnose them as mentally ill, but you do not have to treat them.

Now, not only is that unfair, we also think that it is pennywise and pound foolish, because these children are members of indigent families, at least medically indigent families, and the chances are that if their disturbances or emotional problems are not corrected in youth, not caught and turned around at the early stages, they are going to grow up to have the same problems, or more problems, and be a greater expense, as well as suffer.

There is pending in the Senate a bill to modify this program. It is S. 1392. However, S. 1392 does not correct the shortcoming I noted. There is language in there that still authorizes States to exclude treatment of the mentally disturbed children and we hope that that would be corrected.

At this point, I would like to depart from my prepared remarks and make two observations, personal observations, which I think will be helpful to the committee.

Now, the CMHC program has been in existence since the very year that medicaid got underway and there have been some fantastic successes and there have been some instances of failure. There is no doubt about it.

I would like to tell you of my own experiences with the Community Center in Oak Ridge, Tenn., near where I live. Coming up on the plane, I listed all the people that I referred to that center—I am not a physician or a professional. They get to know that I am with the Mental Health Association and they call me. And of the 10 persons whom I could remember sending, referring, or actually taking, in some cases, to the center, 7 of them are definitely better. One of them, no. And two of them, I just could not say whether they are better, worse, or not. I am just not up on them.

But I know that everyone of the 10 I know personally, and I can testify that 7 clearly are better.

I want to talk just about two specific cases. One of them was a 65-year-old widow whose husband was a speechwriter for the head of a department here in Washington and after he died, she had many problems and moved back to Norris, Tenn., where they had lived in their earlier years. She bought a house.

One Sunday word got to me that Helen was sitting by her front door with a gun. She had actually shot through the door. Living on one side of that woman, was a family that had two small children. On the other side was another woman expecting her first child. They were scared to death.

The police said well, we cannot do anything. We did not see it happen. I kind of have my own views of our local police, but that was their attitude.

I called her up and said, "Helen, what is the problem?" Well, she said, people are trying to break in my house. I am being zapped. I have called the FBI about this and they understand this and they believe me, but there is nothing they can do about it, they say.

I said, "Can I come over and talk with you?" "Yeah."

"Have you got the gun?" "Yes."

"Put it down. I want to come over and talk to you."

So I went over and talked to her and talked her into going to the mental health center. I called our director as soon as he got home from Mass and I said, "Jack, I've got a patient for you." He said, "Bring her over."

I took her over there and she was interviewed and agreed to stay as an inpatient and after about 3 weeks she came out and the hallucinations were gone—I am not saying she is totally well, but the hallucinations were gone and she had forgotten all—is that my light?

Senator TALMADGE. Yes. I am sorry I have to call time on you, but we do have a number of witnesses.

Mr. BRANDT. All right. Let me finish the sentence.

She had forgotten all about the gun—I still have it, by the way. I would like to find something to do with it—she decided she had made a mistake in coming back there, sold her house, moved back to her childhood home in the hills of Kentucky, and as far as we know, she is all right.

Sir?

Senator MATSUNAGA. I just wanted to know what happened to Helen.

Mr. BRANDT. She moved back to the county next to the one where Mr. Nixon was in recently and is in good shape, as far as I know.

Senator MATSUNAGA. I am glad to hear that.

Mr. BRANDT. I have other examples, but my time has expired.

Senator TALMADGE. Your entire statement will be inserted in the record.

How do you define mental health?

Mr. BRANDT. How do I define mental health?

Senator TALMADGE. Yes.

Mr. BRANDT. Would you allow me to define mental illness as an alternative?

Senator TALMADGE. Yes.

Mr. BRANDT. To me, mental illness is any strictly nonphysical impairment—substantial, significant impairment—of a person's ability to function due to some emotional or mental problem. Not a minor upset over a short-term loss, but a substantial inability to function as he or she has been functioning, carrying on his work, carrying on his family, without getting over it.

Senator TALMADGE. Senator Long?

Senator LONG. I have no questions. Thank you.

Senator TALMADGE. Senator Danforth?

Senator DANFORTH. I have no questions.

Senator TALMADGE. Senator Matsunaga?

Senator MATSUNAGA. I have one question, Mr. Chairman.

Is it not true, or is it within your knowledge, that much of the mental health problems or mental illnesses today are treated as physical illnesses, especially among children, because our present law excludes the treatment of mental illnesses among children under medicaid?

Mr. BRANDT. Well, not only among children, Senator Matsunaga. I think among adults as well, that there are people who are placed in hospitals because they have insurance to cover that, yet they cannot be covered if they seek treatment on an outpatient basis. Also, some have to go to M.D.'s because their insurance will not cover psychologists, and so forth. I would prefer to go to a facility that has a mental health team and let them decide which professional is best for my particular case.

Senator MATSUNAGA. So, this present practice prevails among adults as well as children?

Mr. BRANDT. That is right.

Senator MATSUNAGA. The present practice is to treat mental illness as physical illness, because of the language of the present law which, in effect, amounts to the circumvention?

Mr. BRANDT. I think that would be a fair statement; yes.

Senator MATSUNAGA. Thank you.

Senator LONG. Could I just ask a question?

Senator TALMADGE. Senator Long.

Senator LONG. Since you gave your definition of mental illness, I just wondered how you would define this type of situation, where you get a person who has some talent—

Mr. BRANDT. Sir?

Senator LONG. How do you define the type situation where a person lives under a great deal of pressure and the doctor thinks the person ought to take tranquilizers to slow them down but they find that they seem like an old, weary person when they do so they insist on taking pep-up pills instead, and perform very badly with the pep-up pills.

Now, would you define that as mental illness, or what? How would you define that? Would you define that as drug abuse?

Mr. BRANDT. I would define that as inappropriate treatment. I think they had better get them another practitioner.

Senator LONG. But the situation I am talking about is a situation where the doctor is prescribing the right drug. The patient is just not taking it. You see, the patient is taking just the opposite.

Mr. BRANDT. Well, you see, we have all kinds of laws regulating the speed limit, but they are not self-enforcing, so prescription and doctors' orders unfortunately are not self-enforcing.

Senator LONG. You would not call that mental illness?

Mr. BRANDT. I would have to know why he was not doing it. If it was just simply willfulness, he was going to show them, no, I would not call that mental illness. But if there was some problem that he had a compulsion, he could not do what he was asked to do, that would be mental illness.

Senator LONG. Well, just suppose he was just getting old and did not want to live with that situation, thought he could take those pep-up pills and be young again.

Mr. BRANDT. No; the way you put it, Senator, I would not call that mental illness.

Senator LONG. You would call it drug abuse?

Mr. BRANDT. The fountain of youth.

Senator LONG. Or drug abuse.

Mr. BRANDT. Well, drug abuse can be mental illness. Alcoholism can be mental illness. It can be caused by it, or might result from it.

Senator LONG. Might be, or might not be.

Mr. BRANDT. Either way.

Senator LONG. Thank you very much.

Senator TALMADGE. Thank you for your contribution, Mr. Brandt. [The prepared statement of Mr. Brandt follows:]

#### STATEMENT OF SANDFORD F. BRANDT FOR THE MENTAL HEALTH ASSOCIATION

##### SUMMARY

The Mental Health Association recommends the following changes in Medicare and Medicaid to end or reduce discrimination against mentally ill persons:

##### *Medicare*

First priority. Part A. Grant provider status to qualified Community Mental Health Centers for outpatient and partial hospitalization services. To qualify, a Center would have to meet the standards set by Congress in the 1975 mental health amendments (Public Law 93-64) and the implementing regulations issued by HEW. (A bill to accomplish this in part, H.R. 13097, was approved by the House Ways and Means Committee two days ago.)

Second priority. Part B. Decrease the copayment for mentally ill patients from the present 50 percent down to 20 percent, the same as for any other covered illness.

Third priority. Part B. Raise the annual ceiling on reimbursement for treatment of mental illness from the present \$250 up to \$750. There is no annual ceiling for other covered illness.

Fourth priority. Part A. Eliminate the 190-day lifetime limit of coverage on patients in psychiatric hospitals, making the benefits and benefit periods the same as for patients in other hospitals.

#### *Medicaid*

The Mental Health Association at this time is limiting its recommendations to the Early and Periodic Screening, Diagnosis, and Treatment Program. This program is currently in the process of being amended by the pending Child Health Assessment Act, S. 1392. We recommend striking from the pending bill language which permits States to exclude coverage of mentally ill children; this would have the effect of mandating the same coverage as for the physically ill.

#### STATEMENT

Mr. Chairman, I am Sandford F. Brandt of Norris, Tennessee. I am past President of the Mental Health Association in Tennessee and currently a Vice President of the National Association. I have been active as a volunteer in the Mental Health Association for some 20 years. My testimony will describe the ways in which Medicare and Medicaid discriminate against mentally ill persons and will spell out the legislation recommended by the Mental Health Association to end that discrimination.

#### MEDICARE

##### *Medicare discrimination*

Medicare discriminates against the mentally ill both directly and indirectly. It discriminates directly as follows: In Part A, hospital insurance, which is provided automatically to all Medicare eligibles, Section 1812(b) (3) sets a lifetime limit of 190 benefit days in a psychiatric hospital. There is no lifetime limit on time in other hospitals regardless of the diagnosis. In Part B, the supplemental medical insurance available on payment of monthly premiums, Section 1833(c) limits reimbursement for treatment of "mental, psycho-neurotic, and personality disorders" to 50 percent of the doctor bills and other reasonable costs after the deductible. Reimbursement for other covered illness is at the rate of 80 percent. In addition, Section 1833(c) places an annual ceiling of \$250 on reimbursement for outpatient treatment of mental illness (\$202 if the deductible is also for mental illness). No annual ceiling is placed on reimbursement for treatment of any other illness.

The indirect discrimination lies in the fact that the Medicare Act does not recognize Community Mental Health Centers as primary providers of health care.

Medicare and the Community Mental Health Centers program are both creatures of the Congress of the United States. In fact, both were created in the same year, 1965. Although construction grants for Centers had been authorized in 1963, it was in 1965, the year of Medicare, that Congress authorized the heart of the program—federal matching grants for operation of Centers.

Notwithstanding the fact that both programs were started at the same time and notwithstanding the fact that both are aimed at providing better health care, the two programs, Medicare and Community Mental Health, are not integrated. Although Medicare subscribers who are treated by physicians in Mental Health Centers may be reimbursed, treatment by other mental health professionals and other services offered by the Center, in fact, the Centers themselves, are usually not recognized under Medicare.

##### *Recommended legislation*

To overcome this discrimination against our older Americans who became mentally ill, the Mental Health Association recommends the following amendments to Title XVIII of the Social Security Act, in order of priority:

1. Amend Part A by adding to the list of services for which reimbursement will be provided outpatient services and partial hospitalization provided by a qualified Community Mental Health Center. Precedent for this exists in Public Law 95-210, enacted just last year, to grant provider status to Rural Health Clinics. The terms "outpatient services", "partial hospitalization", and "qualified Community Mental Health Center" either could be defined in detail in the law—as was

done with respect to Rural Health Clinics—or the definitions could be incorporated by reference to the Community Mental Health Centers Act, which, as amended by Public Law 94-63 in 1975, lays down very strict requirements which a Center must meet in order to qualify for federal assistance. (At this writing, an amendment which would substantially carry out this recommendation has been approved by the Ways and Means Committee and is now pending in the House; H.R. 13097.)

#### MEDICAID

As the President's Commission on Mental Health recently pointed out, Medicaid is not one program—it is 53 different programs. The Mental Health Association does not feel competent to pass judgment on Medicaid in its entirety. There is, however, one glaring instance of discrimination against mentally ill children in Medicaid as it presently stands. This discrimination is not only unfair but unwise.

A provision of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) under Title XIX permits States to deny treatment to children who are diagnosed under this program as having "mental illness, mental retardation, or developmental disabilities." A bill to improve EPSDT is now pending in Congress (S. 1392, Child Health Assessment Act) but it would not, as introduced, end this discrimination.

The Mental Health Association believes that it is not only patently unfair to deny treatment to the mentally disabled but also that it is "penny-wise, pound-foolish." The surest way to avoid excessive costs of treating mentally ill adults is to treat mentally ill children.

Therefore the Mental Health Association recommends striking the following language from S. 1392: "... but not necessarily including these for the treatment of mental illness, mental retardation, or development disabilities" (lines 10, 11, and 12).

#### PRESIDENT'S COMMISSION

Mr. Chairman, I conclude by noting that the President's Commission on Mental Health, in its final report released April 27 of this year, makes substantially the same recommendations as made by the Mental Health Association before this Committee today. If the Committee has no objection, I will include with my testimony an extract from the Commission's final report covering its recommendations for eliminating from Medicare the present discrimination against mentally ill persons.

Thank you very much. I shall be glad to try to answer any questions the Committee may have.

(Mental Health Association—Exhibit 1)

#### EXTRACT FROM FINAL REPORT OF THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 1978

#### MEDICARE

When Medicare was enacted in 1965, it was modeled after the best private health insurance programs of the times and intended to be an exemplar for progressive public financing of health care. Over the past decade, however, no significant changes have been made in the program. It has not kept up with advances in the delivery of services or with advances made by private insurance programs in financing health care. While Medicare may have been intended to mirror the most progressive private insurance programs of the 1960's, those who see it as a model for national health insurance should look more critically.

Nowhere are the deficiencies of the Medicare program more apparent than in the area of financing mental health care. The program has set an unfortunate precedent in public financing efforts for the discriminatory treatment of people with mental disability. For example, inpatient care in psychiatric hospitals is limited to 190 days over a person's entire life span. In contrast, limitations for inpatient care in general hospitals are framed in terms of each episode of illness. Not only is there a 60 day lifetime reserve, but a person is eligible for 90 days of coverage for each episode of illness, regardless of how many times the person becomes ill.

Further, organized mental health care systems cannot qualify as providers of outpatient services under Medicare unless operated by a general hospital, while physician-directed health care clinics such as neighborhood health centers can. In addition, a patient with physical illness pays 20 percent of the bill for outpatient

care, but the same patient with a mental illness must pay 50 percent of the bill up to \$500 and 100 percent thereafter.

As restrictive as the original Medicare legislation was in regard to financing ambulatory mental health treatment, inflation has further reduced the coverage endorsed by Congress. Since 1965, charges for psychiatric office visits have increased by almost 70 percent. With no corresponding increase in the maximum outpatient benefit, today's elderly are reimbursed for less than half of the services they would have been able to receive a decade ago. As a result of these restrictions, often the only option for diagnosing the problems of or treating the elderly with mental disability is to hospitalize them.

If we are to reduce the financial barriers to mental health services for the elderly, the discriminatory treatment of mental health services under the provisions of Medicare must be eliminated. The Commission recommends:

Amending current Medicare legislation so that:

- (a) Community mental health centers and other organized systems of Community mental health care be given provider status;
- (b) the allowable reimbursement for the outpatient treatment of mental conditions be increased to at least \$750 in any calendar year;
- (c) The beneficiary coinsurance be reduced from 50 percent to 20 percent to conform to Medicare coinsurance requirements for physical illness;
- (d) Coverage for inpatient care of psychiatric disorders in acute care settings be extended so it is equivalent to that provided for physical illness; and
- (e) Two days of partial hospitalization be allowed for each day of inpatient care.

**Senator TALMADGE.** The next witness is Mr. Martin L. Gross, author of "The Psychological Society."

You may insert your full statement in the record, Doctor, and summarize it in 10 minutes or less.

#### **STATEMENT OF MARTIN L. GROSS, AUTHOR OF "THE PSYCHOLOGICAL SOCIETY"**

Mr. Gross. I am Martin L. Gross, author of a book entitled "The Psychological Society," which resulted from my previous research in the field. I have specialized in the psychological, psychiatric, and medical fields as a writer. In doing my research for a previous book called "The Doctors," I spent a great deal of time with American psychiatrists. The result, after 8 years of research, is the present volume. I interviewed hundreds of psychologists and psychiatrists, and found that within the profession there is a great deal of dissension which has been hidden from the public.

When my book came out, it was praised by such prominent people as Dr. Solomon Snyder, professor of psychiatry at Johns Hopkins, Dr. Ronald Fieve at Columbia University, Dr. Stella Chess at New York University, Dr. Arthur K. Shapiro at Mt. Sinai, and others. Last week I received a phone call from a physician who is the head of an important commission of the American Psychiatric Association. He stated: "Your book is terrific, but I cannot say so publicly because I am in enough trouble with the profession as is."

The problem we face in the treatment of mental illness in America is that the psychiatric profession, for economic reasons, has put its effort into the treatment of the well. They are mainly in the private practice of psychotherapy, for people able to afford \$50, \$60, and \$70 an hour. Meanwhile, the treatment of mental illness in America is shameful. In fact, America is the most deficient nation in the civilized world in the treatment of the mentally ill. The reason is basically that

the Freudian psychoanalytic establishment gained control of the psychiatric profession after World War II as a result of the training of American psychiatrists in the armed services by Dr. Carl Menninger, a Freudian, and then in the Veterans' Administration after the war.

The result is that, today, in New York City, for example, for \$60 an hour, perfectly healthy people, including several of my employees—I am also a magazine editor—receive psychotherapy which is reimbursed by health insurance. The people are functioning perfectly and are well. Meanwhile, I have visited many State institutions, county institutions, and Federal institutions, including the Veterans' Administration, and find them staffed by poorly trained, foreign-schooled residents and interns and psychiatrists, many of whom cannot speak the language well and do not know their psychiatric pharmacology.

We have a system in America in which the psychiatric establishment, for economic and cultist reasons, believe in the Freudian and neo-Freudian theories. They spend their energies in private practice in the care of the well in the major urban cities, particularly in Washington, New York, and Los Angeles. The mentally ill of America are in county, State, and Federal institutions, such as the VA, which generally attract only the poorly trained psychiatrists.

I also have a formal statement, and I will now read part of it. Mental illness is one of America's most serious health problems. Almost 1 percent of the Nation suffers from schizophrenia and almost 2 percent more from a form of affective disease, which include depression, mania, and manic-depressive disorders.

The treatment of severe psychiatric disorders in America is shameful. Our county, State, and federally run Veterans' Administration facilities for the mentally ill are often staffed with poorly paid, inadequately trained, psychiatric help.

I visited a hospital in New Jersey where I had difficulty conversing with the psychiatrist because of his lack of command of the language. A friend of mine—a professor of psychiatry in New York—wanted to become a Veterans' Administration psychiatrist to care for the sick and to do research, and was offered \$42,000 a year, which is less than half of his present income, earned by taking care of private patients. He therefore had to refuse the job.

Studies indicate serious misdiagnosis of the mentally ill in institutions as a result of the poor training of the psychiatrist. An individual known to me for 3 years had been diagnosed as a schizophrenic for the past 12 years. I brought him to a friend of mine, a prominent psychiatrist at Columbia University, who, after further diagnosis, found out that the patient also had some affective, or manic-depressive, disorder. He treated him with lithium. The patient, who had been having severe hallucinations for over a dozen years, no longer has those hallucinations. That person had been in Marlboro State, New Jersey, in the Veterans' Administration Hospital, East Orange, and various others.

If the best-trained psychiatrists are not practicing in our institutions, in what way are their efforts being directed? The answer is private psychiatric practice devoted to the less seriously ill, often perfectly healthy patients, who come to their offices at \$50 an hour for treatment which the profession optimistically labels "psychotherapy."

How effective and how medical is the supposed treatment? Inci-

dentially, America is the only nation in the world where psychotherapy is considered reasonable medical practice. I visited a large public mental institution outside of London. The director spent an entire day with me. I asked: "Where are your psychotherapists?" He answered that they do not permit them in his institution.

Patients are treated humanely with modern pharmacology by the best-trained psychiatrists in England, and they have the same, or perhaps better, improvement rate that we have. They do not practice the witchcraft and nonsense of treating the ill with conversation.

Psychotherapy is generally based on the Freudian theory or neo-Freudian theory. Dr. Arnold Rogow, who is a political scientist and a member of the American Psychoanalytical Association, estimates that two out of three of our psychiatrists are Freudian oriented. As a matter of fact, over half of the departments of psychiatry in America are headed by psychoanalysts. In New York, a prominent psychiatrist was fired from Cornell University, because he was anti-Freudian, when a Freudian took over that institution.

Is psychotherapy accurate, or is the belief that psychotherapy cures a modern superstition that costs the Nation and the Government billions of dollars?

First, can psychotherapy help the mentally ill? Dr. Philip May, who is Director of Research of Psychiatry at the Veterans' Administration Hospital in Brentwood, Calif., was told as a young resident that he was not sufficiently efficient because he was not curing schizophrenics with psychotherapy.

When phenothiazines—the antischizophrenic drugs—came into use, Dr. May conducted a research study at Camarillo State Hospital in California where the patients were divided into groups.

One group of patients were given the phenothiazines, antischizophrenic drugs; another was given electric shock treatment; the third were given nothing or milieu treatment; and the fourth were given psychotherapy.

The patients were evaluated before and after by the entire staff, including Freudian analysts. The conclusion was that psychotherapy was the poorest form of treatment and that nothing did better for the patients than psychotherapy. The best treatment, of course, was psycho-pharmacology.

Incidentally, America is behind all other patients in the use of pharmacology for the mentally ill. A very common antidepressant in England which has almost no side effects—while the ones we use here have considerable side effects—is not allowed in medical practice in America because of FDA regulations. It is only now being used experimentally at the Psychiatric Institute at Columbia Medical Center. It will probably take years before it is provided to the American public.

Psychotherapy is a poor treatment for the mentally ill. Is it a good treatment for the well?

Before I get to that, let me state that for 40 years, the profession was told that mental illness was psychogenic, that is, caused by the environment, or psychological forces. This conclusion came out of Freudian theory.

But modern research indicates that mental illness is almost entirely biological in origin. Dr. George Winokur, then at Iowa Psychopathic,

traced the family history of severely depressed people and found that one out of seven of the relatives, many of whom were not well known to the patient, had a similar disease.

At Maudsley Hospital in England, Dr. Irving Gottesman of the University of Minnesota and John Shields, of Maudsley, traced every patient who entered the establishment for 16 years and found that the identical twins shared schizophrenia 50 percent of the time, while the fraternal twins, who are two different individuals genetically—the identical twins being one individual—shared mental illness only 9 percent of the time.

All studies indicate that when identical twins have schizophrenia, that their cotwin has it five to six times more often than in fraternal twins, which indicates the genetic base of the disease.

The most pertinent study—I think supported partially by the U.S. Government—was done by Dr. Seymour Kety, of Harvard, and colleagues. With the cooperation of the Danish Government they found every child of schizophrenics in Copenhagen for a 24-year period and then located everyone that was adopted away at birth. They found that despite their being adopted away into a normal home, 32 percent of the children had schizophrenic spectrum disorders 10 times more than normal.

This indicates that the Freudian environmental theory of mental illness is an absolute hoax. We are dealing with a serious biological disease which requires the efforts of the U.S. Government, the psychiatric profession, and additional research.

Now, what about psychotherapy for the well? If it does little for the mentally ill, what does it do for the well?

We have a paradox within the profession. Even those who believe in psychotherapy and the Freudian theory have a residual scientific base because of their medical training. Dr. Norman Q. Brill, professor of psychiatry at UCLA and former chairman of the department, whose father was A. A. Brill who translated Freud into English, decided to test his own work. He conducted a well-controlled study with patients who were divided into groups at the university's outpatient clinic.

One group was given sugar pills, plain placebos with no medical value whatsoever. Another were given minor tranquilizers, such as librium, which have no real, strong lasting effect in treating mental disorders. A third group was given the normal psychotherapy. A fourth group was told there was no one available and they had to wait for treatment.

The patients were evaluated by a psychiatrist beforehand and afterward. Dr. Brill reported his findings in the "Archives of General Psychiatry"—and I have interviewed him several times since. He reported that all four groups improved equally well. Sugar pills did as well as so-called psychotherapeutic treatment.

Dr. Louis Gottschalk, at the University of California, at Irvine, who runs the Crisis Intervention Center, asked himself: "What if I do not give the people who come to crisis intervention any treatment?"

He decided to have them wait, instead. He gave another group 6 weeks of treatment and followed them up before and after. He reported back to his profession that time itself—6 weeks of doing abso-

lutely nothing medically, did as well as the 6 weeks of treatment at the University's Crisis Intervention Center.

This has been repeated at the Kaiser Foundation Hospital in Oakland, at Johns Hopkins in Baltimore, and at various other places. These studies indicate that waiting lists do as well as psychotherapy in the treatment of patients.

Dr. Lester Luborsky, at the University of Pennsylvania, has studied all the studies. He has spent years doing this, and he is one of the most renowned researchers in America. He took 166 of the profession's studies and he found the following:

That if you are quite intelligent and are educated, that psychotherapy does better than if you are not.

That if your social class is higher, it does better. And if your social class is closely related to that of the therapist, it does better.

That psychotherapy does well only if you are not very ill. If you are very ill, it does very little.

This is not a medical or scientific treatment. It diverts the energies of the profession, which is most important, from the treatment of the mentally ill. The money in the profession is to be made in the private offices taking care of the so-called neurotics—who are often not really neurotics. Meanwhile, the mentally ill who have no money to pay for doctors get the most miserable psychiatric treatment in the world,

There is no civilized country in the world that does as poorly in treating its mentally ill as does the United States.

Now, does anyone need training to do psychotherapy? It is not a medical technique. It is a professional technique?

This is a very trying question which came to the attention of Dr. Hans Strupp at Vanderbilt University in Nashville. Dr. Strupp is a research psychologist—who, by the way, believes somewhat in psychotherapy. I must say, in behalf of the profession, that even those who are cultists, faith healers, witchcraft believers, still, as physicians and Ph. D.'s, do some scientific research. They have reported in their journals, have told it to me, and I have put in my book. I have brought it to the attention of the public and I will bring it, I hope, to the attention of the U.S. Government.

In this study, Dr. Strupp went to the medical schools and asked for their five best therapists. They gave him three M.D. psychiatrists and two Ph. D.'s—the best men in Nashville, Tenn., according to the university. They took 15 patients in the outpatient clinic and gave these patients to the doctors to treat. With psychotherapy, that is, without medication.

They then went to the students at the undergraduate school at Vanderbilt and asked for the teachers they liked: professors in English, history, mathematics, economics, philosophy. They named seven teachers.

They took 15 equally matched patients from the outpatient clinic and gave them to the teachers and said, just do what you can for these kids. The medical school evaluated the patients beforehand and afterward and reported back in an unpublished study, which Dr. Strupp has given to me. He is possibly now sorry that he gave it to me. The college liberal arts and science professors, according to the psychiatrists, did as well as the professional therapists. The reason

is because psychotherapy is not a specific technique. It is a conversation between two persons which can help the person, as all conversations and human relations can, or it can do nothing for the patient, or it can harm the patient.

Dr. Strupp has also queried 150 of his colleagues and has reported back that 1 in 10 patients are actually harmed by psychotherapy.

Some members of the profession are becoming aware that they have been involved in the greatest intellectual hoax of the 20th century. The American Psychiatric Association has appointed a committee to revise the present diagnostic manual—the present DSM-2, or diagnostic and statistical manual. The American Psychiatric Association's present manual is replete with Freudian cultist definitions of mental illness. The new manual, a draft of which was given to me, revises all of this.

Senator TALMADGE. I am sorry to call time on you, but—

Mr. GROSS. All right. Just very quickly, my last sentence is that the diagnostic manual is being revised. The word "neurosis" has been exorcised from the new manual and replaced by "anxiety." All psychological definitions of mental disorders have been removed.

Gentlemen, we face the need for the U.S. Government, through medicare, through medicaid, through the coming national health insurance, to divert the energies of the psychiatric profession, from the economic gain in private practice through the use of a cultist technique called psychotherapy into research into pharmacology, into the treatment of the mentally ill. We must take them out of the offices of Park Avenue and bring them into the mental hospital to care for the seriously mentally ill, because this is the shame of our Nation.

Thank you.

Senator TALMADGE. Mr. Gross, I understand that, in your book, you describe parents as being falsely accused of causing their children's emotional problems. Will you tell us why that is so?

Mr. GROSS. Through people like Dr. Spock and the Freudian establishment, parents for the last 40 years—and only in America—have had the onus of being blamed for causing everything from schizophrenia to nail biting to hyperactivity. The reality is that parents have very little to do with the emotional behavior of the children. They have a lot to do with their politics and their table manners, but very little to do with their emotional balance, except through the passing on of their genes.

Dr. Stella Chess of New York University in the 1950's said, "I want to watch children to see how they grow up." Her colleagues at New York University said, in effect, "Freud has already told us about the cause of mental illness and emotional disturbance."

And she said, "Well, I'll watch anyway." And she has watched for 22 years. She has written two books. I have reported them in my book. I have interviewed Dr. Chess at great length. I have reported my findings back to her for her approval, and she recently sent me a letter of commendation. What Dr. Chess stated in her books is now changing the world of child care. She learned that the child's natural temperament at birth, which she observed from the crib on—whether shy, aggressive, or whatever—is generally a reality of birth. The

parent reacts with the child only by understanding the child's biology and using it, or trying to shape it somewhat.

The concept that the parent is to blame for the child's mental illness is a serious crime of the psychiatric profession.

James Wechsler, editorial page editor of the Post, wrote a book about his schizophrenic son who committed suicide. He was insulated by every psychiatrist—I believe there were eight of them—that he and his wife were to blame for the child's schizophrenia. We now know, as the result of some research by Dr. Kety and others, that schizophrenia is basically an inborn disease.

Dr. Loretta Bender, who was once a Freudian and the head of child psychiatry at New York University, and whom I interviewed has now come complete circle. She sees that childhood schizophrenia is a genetic and biological in basis, possibly the result of intrauterine damage during pregnancy, or injury during the act of birth itself, among other causes.

We have been faced in America, and in America only, with a psychiatric establishment that blames parents, that blames the environment, then poorly treats the patients. This is because it is heavily involved in Freudian witchcraft.

Senator TALMADGE. Now, how does psychotherapy relate to faith healing?

Mr. GROSS. Dr. Raymond Prince of McGill University in Canada spent time with the Yoruba witch doctors in Nigeria and reported back that they are as effective in the treatment of minor mental illness as American psychiatrists. They, too, do psychotherapy, and psychotherapy is a belief system. If you tell a person through 10 years of psychoanalysis that their parents caused their ailment. If you trace their infantile complexes and get them to believe in this system, it gives the patient a structure on which to place their anxiety.

The Yoruba witch doctor may say that a great aunt's spirit is defying them. The Navajo shaman may say that the child's spirit has not yet ascended to the heavens.

Faith healing and American psychotherapy are the same practice, in that if the patient believes and is not really sick he may get well. Studies show that if a person who believes in Freud goes to a Jungian, he does not get better. If he believes in behaviorism and goes to a Freudian, he does not get better. You must believe in the theorem.

Dr. Luborsky showed that all treatments, no matter how contradictory, do as well. The reason is that two out of three patients get better in psychotherapy or without psychotherapy because they are going to get better through time itself.

The seriously mentally ill do not get better in psychotherapy or without psychotherapy. The seriously mentally ill only get better through medication: antidepressants and antischizophrenic drugs.

Let me give you an example of the shame of American psychiatry. A drug called beta-endorphin has been discovered by C. H. Lei, a brilliant scientist at the University of California in San Francisco. One of the psychiatric institutes in America tried to get this drug for a controlled experiment, but Lei does not have the money: it costs \$3,000 a dose. The drug companies will not make it. The U.S. Govern-

ment does not subsidize drug research sufficiently, and so such controlled studies cannot be done.

The work done by Dr. Nathan Klein in Manhattan, in his own private practice (he is a two-time winner of the Lasker awards) indicates that beta-endorphin, which comes from our own pituitary, may be one of the great breakthroughs in the treatment of schizophrenia, psychotic depression, phobias, and obsessions. But we cannot do the proper research into it because we do not have the money, and because most of the energies of the profession are divided to the so-called neurotic well who have \$60 an hour to pay for these doctors.

Senator TALMADGE. Mr. Gross, how is neurosis and neurotic behavior defined?

Mr. Gross. Well, it has been defined by American psychiatry. But next year it is being thrown out after 40 years. It is supposedly a conflict between the infantile id and ego and superego which results in a symptom compromise such as a twitch or not feeling well or an inability to work. This is, of course, absolute and total nonsense.

It is blamed, by many psychiatrists, on infantile sexuality. Dr. Paul Chodoff, a brilliant, Washington, D.C. psychiatrist who is also a child psychoanalyst has stated to me that this is pure nonsense. There is no such thing as infantile sexuality. This was an invention of a distorted, near-psychotic named Sigmund Freud whose ideas are honored only in the United States.

Sigmund Freud once said in letters to Wilhelm Fliess that neurosis is caused by the sexual seduction of children, by nursemaids, parents, relatives at an early age. Then he wrote to this same friend that he was wrong. "My patients lied to me, or perhaps I put the idea into their heads," Freud said.

Then later, he said, "Ah, but if they thought they were seduced, they had the fantasy of seduction, which is as important as the real seduction." From this he invented the theory of infantile sexuality, which has distorted American psychiatry beyond belief.

We are laughed at in England and Germany; in Switzerland and Sweden; in Holland, in Russia—in every nation in the world. We are laughed at because of our concentration on psychotherapy and Freudian psychology, which has distorted the profession and has given economic gain to psychiatrists. They have these ridiculous theories to practice on the well while our mentally ill live in snakepits.

Senator TALMADGE. Mr. Gross, in the interests of time, I am going to have to ask you to make your answers as brief as possible.

Mr. Gross. I shall try.

Senator TALMADGE. You also claim that millions of Americans have been falsely labeled and self-incriminated as neurotic. What do you mean by that?

Mr. Gross. The normal anxieties and vicissitudes of life—a death in the family, a loss of a job, the feeling of inadequacy—are faced by people in Nigeria or in Iceland or elsewhere. But in America, it is cause for a person to consider himself neurotic. When he is nervous, or anxious, he goes to a psychiatrist for treatment.

Anxiety and nervousness, are the normal lot of man. We are a nervous animal, and we are anxious. You see a great deal of anxiety in

Washington, D.C. This is not neurosis. That is the normal lot of the intelligent individual.

But in America, the psychiatric profession says that if you are anxious and nervous, there is something wrong with your mental health. You should go to a doctor.

Seven million people a year run to the doctor for such treatment. This is pure stupidity. Most of them get better in psychotherapy. But, of course, most of them also get better if they go on the waiting list. The reason is that there is nothing wrong with them whatsoever.

I had several workers in my office in psychotherapy. They are making \$15,000 and \$20,000 a year, and are functioning beautifully. They are perfectly normal, but consider themselves "neurotic." Neurosis is a metaphysical fantasy invented by Sigmund Freud which the profession hopefully will eliminate in their new diagnostic manual in 1979.

Senator TALMADGE. You claim that schools and courts rely on misleading psychological and psychiatric evidence.

Mr. GROSS. The courts in America are a center of foolishness. A man shoots someone in cold blood and swears on a Bible that he shot the man in cold blood. The defense brings in three psychiatrists who say: He was temporarily insane: he has psychomotor epilepsy; he is schizophrenic, et cetera; he did not know what he was doing at the time. He was out of his mind, and therefore he is not responsible for the crime.

When Sirhan Sirhan assassinated Robert Kennedy, the defense brought in a battery of witnesses saying that Sirhan was insane and the prosecution brought in a battery of witnesses saying he was sane. This was testimony from the same profession on the same patient. Half say he is sane; half say he is insane. They found that the psychiatrist for the defense was cribbing his testimony on Sirhan Sirhan, almost word for word, from a textbook on the Mad Bomber case in New York.

The reality is that the metaphysical state of the patient when he has shot somebody is of no importance to intelligent people interested in jurisprudence.

If the person is mentally ill at the time of the trial, the person should then be placed in a hospital for the criminally insane and treated for his mental illness. At such time as he is cured, he should then go on trial for the murder.

The metaphysical state of the person is of no importance in the question of crime.

Senator TALMADGE. What were your findings with respect to the validity and acceptance of the Freudian theory?

Mr. GROSS. Before I answer that, just one brief comment in regard to the schools. We have 7,000 school psychologists and 60,000 guidance counselors who think they are psychologists who test and treat children with psychotherapy, which they call counseling. They give them psychological tests seemingly every time a child gets a D and has exhibited bad conduct.

The failure is in the curriculum, the failure is in the parent, the failure is in the school, the failure is in everything except in psychology. Yet psychology is the remedy for all the failings of the society and the civilization.

The schools are not the place in which to center psychology. As a matter of fact, the school psychologists in most States need not be licensed psychologists in order to practice on our children.

Now, to get to the Freudian theory. The Freudian theory is totally and absolutely unsubstantiated. Every attempt to substantiate it has failed. Every attempt to show that it is false succeeds.

The Freudian theory, for example, states that people forget their dreams because they repress them. Dr. Alan Rechtshaffen of the University of Chicago, showed instead that when you wake people up, almost all remember their dreams. But most forget them 5 minutes later, because there is no long-term memory chemical in the brain to hold those dreams.

The Freudians said that penile erections in children were a sign of infantile sexuality. But Dr. Halverson found that it was the result of abdominal pressure. The minute the child urinated, the erection went down.

The Freudian theory has had no substantiation whatsoever. They have gained control of American psychiatry as the unfortunate result of the World War II training by Freudians. As a result, we are laughed at in the rest of the world.

**Senator TALMADGE.** Senator Long?

**Senator Long.** I read this book by Norman Vincent Peale some years ago, "The Power of Positive Thinking," and it seemed to me that that can be useful to people who have anxieties and problems where they tend to be negative in their point of view, and I would think that applying just the principles that that preacher advocated in that book would be helpful to people.

Now, particularly with regard to anxiety, what is your reaction to that type of thing? I guess you know what I am talking about.

**Mr. Gross.** I do completely, Senator.

Everyone needs some method of alleviating anxiety in life. We used to have a Judeo-Christian ethic, church, synagogue, belief in God. That was a very strong support and it made it possible for people to reduce their anxiety because of their belief in God.

As the belief in the divinity of Jesus and the supremacy of the Patriarch in Heaven diminishes, people turn to other sources. Some go out for tennis, some are born-again Christians, others go bowling, others go to Alcoholics Anonymous—which, by the way, does a far superior job to the psychiatric profession in the cure of alcoholism. Others go to psychotherapists.

I have nothing against a perfectly normal person who has anxieties going to a psychotherapist and paying his money to replace the belief in God that he once had. But to call it a medical technique is shameful.

I think everyone should think positively. Everyone must find a way to reduce anxiety. We live in a complicated society. We have very high taxes, and those high taxes make us anxious, and we have to find a way to reduce it. Until such time as taxes are reduced, until such time as public transportation is better, gasoline is cheaper, wives are more agreeable, we need some method.

If a person wants to go to psychotherapy, that is his privilege. But it has no place whatsoever in medicine—except as tender loving care along with the use of medication. If a psychiatrist is pleasant and

friendly and will talk to the patient tenderly and nicely, there is nothing wrong with that.

**Senator LONG.** There is another book that I had in mind, also written by a preacher, named "Forgive Us our Trespasses." It was the same man who wrote the book, "Magnificent Obsession."

Now, I would think that if one tended to be paranoid, to read that book would be a tremendous help to him, help him to understand that people who do injustices to others do not really do it because they want to hurt the other person, they do it just out of selfishness or weakness of their own character, and that those people should be forgiven, rather than hated.

One who feels he has been done a grave injustice might be inclined to either murder someone or commit mayhem where he should feel sorry for a person who knows no better than to do that kind of unfair and unkind thing to his fellow man.

Now, what is your reaction to that? It seems to me as though that is good psychology, and again, that is related to religious teachings.

**Mr. Gross.** Self-indulgence and poor character are becoming the hallmark of American society, and psychiatrists rush in and exploit that for gain.

If we were to become a people who were once again self-reliant, we could divide mental health and mental illness into simple categories, perhaps three.

One, those who are simply and clearly mentally ill: the manics, the depressives, the manic-depressives, the schizophrenics, those who have schizoaffective combinations.

The second would be a borderline group which appears to be biologically related to these groups. Those are people with extreme anxiety who cannot function; those who have obsessive-compulsive disorders, like washing their hands all day long; and those with phobias who cannot stand heights or ride on buses or stay in closed places.

Once we get through those major categories, the rest of us are quite sane, quite normal, and quite nervous. This is not a call for psychiatry. This is a call for finer character, for social structure, for lack of self-indulgence, for strength and for a better culture.

The problem is that the psychiatric profession has convinced people that nervousness and anxiety and self-indulgence and selfishness are all part of the "mental illness" syndrome. This has thrown millions of patients into doctors' offices for psychotherapy. This is a shameful situation which has done great harm to this Nation.

As I say, it does not take place elsewhere in any quantity. People in Holland do not run to the psychotherapist when they have a divorce, or someone dies. They turn to themselves, to their friends, to their clergymen and to society for sustenance.

In America, we run to the psychiatrist. We so confuse the situation that those who are truly mentally ill cannot get the services of these psychiatrists because they are making their money taking care of the self-indulgent well. The Government can help by putting more money into biological research for the mentally ill, by better supporting mental institutions in the States, the counties, and the VA and Federal Government, and by bringing in the board-certified psychiatrist into the hospital, even if you have to pay him \$75,000 or

\$100,000 to work full time in that office. Then he will do what all other doctors do—make his money off the sick. The psychiatrist now makes it off the well. As a result, the sick are not being taken care of.

The Government, I think, is the only agency that can turn this around. It can be done by giving proper support to the mental institutions and making them the true center for psychiatric treatment.

Senator LONG. I would just like to ask one more question.

It has been quite a few years ago that a book, which was at that time a bestseller, was written by a man who had been a very successful novelist. He had been a doctor before he wrote the book. The name of the book is "The Citadel."

Have you ever read that book, or heard of it?

Mr. Gross. I have not read it, but I have heard of it. Mr. Cronin, no?

Senator LONG. Yes.

I would commend it to you. You might have a little difficulty finding it, but it was a bestseller and when the American Medical Association appeared before us some years ago, I asked the witnesses if they had read that book, and they said no, they were not familiar with it.

But it seemed to me that in that book you had very—and mind you, the book was at least 20 years old—and in that book you had the very indictments of the medical profession stated 20 years ago by a doctor, which was a best seller across the land—and that is basically indictments against which the medical profession is guilty even today.

Just one simple little thing that I have had on my mind since I read that book. A so-called society doctor, just butchering that poor patient to death, right there on the operating table, when he was purely incompetent, clearly incompetent, to operate on that person.

Here we are today paying, in some cases paying a general practitioner even more than you would pay a surgeon, and nobody ever asks the qualifications of somebody to cut someone open with major surgery, whether he had performed that operation before, or performed anything similar, when you have another doctor right nearby who could have performed that operation and the patient would have survived.

I know of cases, some of which were close to me, where—at least one of which was very close to me—where a patient died because one doctor operated and there was another standing right there who could perform that operation successfully.

Mr. Gross. I wrote a book called "The Doctors," in 1966 which the American Medical Association attacked. In the last 12 years, virtually every action of the medical profession has substantiated all of my charges, including what you are talking about.

The medical profession is venal, in economic terms. They are excessively rich. They are greedy. They do not provide proper services. It is a conspiracy profession.

I wrote in my book that I was against socialized medicine because I am an antisocialist. Yet in this one area, I have virtually begun to turn around, because they have abused medicaid and medicare. You can readily see the cheats in the profession. They have fundamentally abused the practice of medicine.

**Senator LONG.** Well, I am going to urge you to please reconsider your situation with regard to your profession. I am a lawyer, and I am not sure we are a bit better.

The only difference between the two professions that I can see is that the doctors have the privilege of burying their mistakes.

**Mr. Gross.** The other thing, of course, is that we can sometimes avoid lawyers and we cannot avoid the doctor.

**Senator LONG.** Thank you.

**Senator TALMADGE.** Senator Matsunaga?

**Senator MATSUNAGA.** Thank you, Mr. Chairman.

Are you a doctor of medicine?

**Mr. Gross.** No, I am not. As a young man, I took special science training in high school and then I studied to be a scientist, but later switched to journalism, and I have been a journalist all my life.

**Senator MATSUNAGA.** Are you a psychologist?

**Mr. Gross.** I am not a psychologist or a psychiatrist, but I do my homework.

**Senator MATSUNAGA.** When I was in high school, my English teacher, Mrs. Isabelle Andersen—I remember her so well because she was such a powerful character—used to say, "We are all insane. We institutionalize only those who are more insane than others."

It seems, from what you say here, that perhaps even those who render psychotherapy are even more insane than those whom they treat.

**Mr. Gross.** The psychotherapist—

**Senator MATSUNAGA.** I cannot quite understand the conclusions you reach, because I cannot understand the basis of such conclusions. For example, you talked of four cases wherein one was given psychotherapy and that patient fared the worst.

Well, you speak of mental illnesses in that case. What about treating physical illnesses? Would you consider, for example, tonsilitis a physical illness? I suppose you would.

**Mr. Gross.** Well, a tonsillectomy—

**Senator MATSUNAGA.** No, I'm talking about tonsilitis, the illness.

**Mr. Gross.** Well, the illness of tonsilitis almost never exists now, because tonsillectomies are an operation performed for a nonexistent illness. The tonsil was given to us to—

**Senator MATSUNAGA.** Well, let us take the case of a cold. Would you consider that to be a physical illness?

**Mr. Gross.** I suppose a cold is a very minor physical illness; yes.

**Senator MATSUNAGA.** All right.

Supposing there are four persons with similar colds, let us say. One is given sugar pills; one is given aspirin; one is given an antihistamine; and one is given penicillin.

**Mr. Gross.** They all get better.

**Senator MATSUNAGA.** They all get better.

**Mr. Gross.** Unless they get pneumonia.

**Senator MATSUNAGA.** You say they all get better. Supposing the fourth one was given penicillin and he was allergic to penicillin and he fared worse. Would you then conclude that penicillin was the worst of all the treatments for the common cold?

Mr. Gross. No, no. Penicillin is never considered the proper treatment for the common cold. Psychotherapy is considered the proper treatment for emotional disturbance.

Since penicillin is not considered the treatment, it should not succeed, and does not.

Psychotherapy is considered the treatment and does not succeed, so the parallel there, Senator, is false.

Senator MATSUNAGA. I think you missed the point I am driving at. The point is, when you take any four patients, assumedly with the same type of illness, physically or mentally, you must consider the fact, the truth, that no four persons react in exactly the same manner to the same treatment.

Mr. Gross. Sir, these are not—

Senator MATSUNAGA. Not only to the same treatment, but because each individual is unique, they will have varying sensitivities toward a specific illness. Let me give you an example of this to illustrate my point. I have five children. Same parents, same environment. But they are all different.

One is allergic to pollens, another is allergic to shrimps, and another is allergic to coal dust. So the treatment for each child if they suffer from a so-called allergy, would be different and each one would react differently to the treatment.

Of course, you are very forceful and very persuasive, but we are, today, dealing with legislation which recognizes that perhaps we are making a mistake in not taking into consideration mental illnesses as much as we do physical illnesses.

Mr. Gross. Sir, I agree with you that mental illness is ignored and neglected in this country. Legislation which will increase the coverage for true mental illness and the Government support thereof, I support wholeheartedly.

However, psychotherapy, done by a psychiatrist, psychologist, social worker, bartender, college professor, or tennis teacher, is not an effective scientific technique and cannot, with good conscience, be covered by anyone.

Senator MATSUNAGA. Whatever the term may be and whatever treatment you may describe, are you saying that the term "psychotherapy" is so fixed that each doctor would follow exactly the same steps in rendering psychotherapy?

Mr. Gross. Oh, no. There are 168, at last count, psychotherapies in America, none of which agrees with any of the others. They all have contradictory techniques. They all work equally well, because they do nothing.

Senator MATSUNAGA. Do you consider that to be bad?

Mr. Gross. No, no. Sir, I do not think you understand my premise, or the premise of the researchers in this field.

Dr. Luborsky, in studying 166 of the studies, stated the first result: All therapies do as well. The reason all therapies do as well is because people who are not mentally ill get better. You get better whether you go bowling or you take psychotherapy.

If you are mentally ill, you do not get better because psychotherapy is of no avail.

What we must do, I think, through legislation, is support the treatment of the mentally ill in several ways. No. 1—

Senator MATSUNAGA. Let me understand you, then. You are not here testifying that we ought not to concern ourselves with mental illnesses?

Mr. Gross. Quite the opposite. The mentally ill are neglected in America—

Senator MATSUNAGA. I was fearful that, perhaps, you—

Mr. Gross. No, no; quite the opposite. I have spent a great deal of time visiting mental institutions, talking to patients and doctors. The treatment is shameful, the staffs are inadequate, there is insufficient money, because the psychiatric profession has done a shameful job of spending its energies at \$50, \$60, \$70, now \$80 and \$90 an hour in the big cities, taking care of the "neurotic well."

Senator MATSUNAGA. Let me be more specific. With reference to the legislation before us, in as much as I am a coauthor and co-sponsor of a number of them, are you opposed to the inclusion of psychiatric nurses, psychologists, and paramedicals who are trained in the diagnosis and treatment of mental illnesses, to be included within the scope of medicare-medicaid?

Mr. Gross. In an institutional setting where the person is clearly mentally ill, any support given to the patient, I support. But it is antiscientific, antimedical, and anticommonsense to pay for psychotherapy in the office of a social worker, psychiatric nurse, or a psychologist because he cannot perform a scientific or medical technique. He has no training or equipment to do so, because all he can do is what we call psychotherapy, which research has indicated does not work.

Therefore, for the Government to support the activity of nurses, social workers, and psychologists in private settings, not institutionalized patients, would be absolutely ridiculous, except in those cases where the person was "mentally ill," had been released from a hospital, and had some type of service required for followup.

But the private practice of psychotherapy is an antimedical, an anti-scientific, an antitruthful activity, and the Government should not support it; no.

Senator MATSUNAGA. Well, I am afraid that the answer will be much too long if I ask this question.

Mr. Gross. If you ask the question, I promise a short answer.

Senator MATSUNAGA. This will be my last.

What you just stated would seem to contradict your earlier statement that medication with tender loving care—

Mr. Gross. A psychologist cannot give medication, nor can a social worker. All they can give is tender loving care.

Senator MATSUNAGA. Right, right. But then you seem to stress "tender, loving care."

Mr. Gross. Yes.

Senator MATSUNAGA. This is what is necessary.

Mr. Gross. I believe in that, sir.

Senator MATSUNAGA. Well, I would think that a trained psychiatric nurse, or social worker, would be better able to give tender, loving care to the patients.

Mr. Gross. The people who go to a social worker, by definition, could not be mentally ill because a social worker could not give medication, which is the only known treatment for the mentally ill. Therefore, the people who would go to a clinical psychologist would therefore, by definition, not be ill and therefore, you could not cover them.

A psychologist cannot treat, by law, by training, and by research practice, a mentally ill person. Only a psychiatrist can, and he can only treat that mentally ill person with medication.

Psychotherapy is tender, loving care which can be—of course, some psychotherapy is not even tender—tender, loving care as an accompaniment to medication.

No; I would not be in favor of psychologists, or social workers, or nurses receiving reimbursement for private practice psychotherapy under the law; but only in an institutionalized setting where the patient is mentally ill.

Senator MATSUNAGA. Thank you.

Senator TALMADGE. I will pass over the next witness until Senator Dole arrives.

[The prepared statement of Mr. Gross follows:]

#### SUMMARY OF REMARKS BY MARTIN L. GROSS

Mental illness is one of America's most serious health problems. Almost 1 percent of the nation suffers from schizophrenia and almost 2 percent more, according to a reliable estimate by Dr. George Winokur, suffer from some form of affective disease which includes severe depression, mania and manic depressive disorder.

The treatment of severe psychiatric disorders in America is shameful. Our country, state and federally run Veterans Administration facilities for the mentally ill are often staffed with poorly paid and often inadequately trained psychiatric help. A personal visit to the psychiatric ward of a Veterans Administration hospital in New Jersey, for example, showed that much of the staff was composed of foreign medical personnel, some of whom had difficulty with the language and some of whom proved to be insufficiently trained in modern psychiatric pharmacology. Similar visits to state institutions show this to be a typical pattern.

A distinguished psychiatrist, a Clinical Professor of Psychiatry at Mt. Sinai School of Medicine in New York, sought to do full-time work in a Veterans Administration hospital, but was offered only \$42,500 a year, which for economic reasons he had to refuse.

Studies indicate significant amounts of misdiagnosis of the mentally ill in the institutions, a case of which recently came to my personal attention and which I will detail during my testimony.

Once a severely ill patient is discharged from a mental hospital, or has not yet been hospitalized, he is often in a hospital out-patient clinic, generally staffed by young residents-in-training, or even by non-medical psychiatric social workers.

If the best trained psychiatrists are not practicing in the state, county and federal institutions in America on a regular basis, in what direction are their efforts being directed in the field of mental health?

The answer is a private psychiatric practice devoted mainly to the less seriously ill, and often perfectly healthy patient, who has come to their office at approximately \$50 an hour for a treatment which the profession has optimistically labeled as "psychotherapy."

How effective, and how medical, is this supposed treatment? Why is so much professional energy diverted from the treatment of the hospitalized and out-patient mentally ill to the practice of this verbal art which, incidentally, is popular in only one country in the civilized world—the United States.

Psychotherapy is most often based on the Freudian theory, or as adapted by many American practitioners, neo-Freudianism. Dr. Arnold Rogow, social scientist and member of the American Psychoanalytic Association, estimates that two

out of three American psychiatrists consider themselves Freudian or neo-Freudian.

The Freudian and neo-Freudian theories consider that both mental illness and a condition called "neurosis" are created during the first few years of life, mainly by parental influence in the form of an unconscious, unseen psychic confrontation between forces which the profession has labeled id, ego, and superego and more recently, the defense mechanisms.

Since the conditions of mental illness and neurosis are supposedly psychogenic, that is caused by the psychological environmental influences on the emerging person, then a psychotherapeutic treatment which involves verbal and human interaction between the patient and the psychiatrist would supposedly unravel the cause and eventually result in a "cure" of these conditions.

Is this true? Or is the belief that psychotherapy "cures" a modern superstition which is costing the nation and the government billions of dollars and diverting funds and professional energy from the medical and scientific treatment of serious mental conditions?

Firstly, can psychotherapy help the mentally ill? Dr. Phillip May, director of psychiatric research at the Veterans Administration hospital in Brentwood, California, decided to investigate this claim. As a young resident he was told by his Freudian teachers that failure to cure schizophrenia through psychotherapy was the result of his own professional inadequacy.

Later on Dr. May decided to investigate whether this was true. When the phenothiazines were introduced for the treatment of schizophrenia, Dr. May set up a controlled experiment at Camarillo State Hospital in California. There the effectiveness of phenothiazines, electroshock therapy, milieu (or simple hospital environment without additional treatment) and psychotherapy were compared. The results showed that psychotherapy was the poorest of the four treatments. Psychotherapy patients stayed in the hospital longer than those who received no direct treatment at all. Dr. May's "Treatment of Schizophrenia" is now a classic guide post for his more gullible psychotherapy-oriented colleagues.

Recent research indicates that not only is psychotherapy not valid for the treatment of the mentally ill, but that mental illness itself is not caused by environmental factors as the profession had so long claimed.

Work by such brilliant researchers as Dr. Solomon Snyder of Johns Hopkins indicates a neuro-transmitted maladjustment in the brain of the mentally ill. Studies by Dr. Seymour Kety of Harvard, Dr. George Winokur then at Iowa Psychopathic, Irving Gottesman of the University of Minnesota, and John Shields of Maudsley hospital in London, indicate that relatives often unknown to the patient showed a high statistical correlation in having the same form of mental illness, that identical twins shared mental illness five times more than fraternal twins, and that children of the mentally ill adopted away at infancy developed an abnormally high incidence of mental illness despite the fact that they were raised in normal foster homes.

This last work, done in cooperation with the Danish government, showed that children of the mentally ill developed "schizophrenic spectrum disorders" over 30 percent of the time despite their being brought up in normal foster homes. This incidence is approximately 10 times normal and similar to what one would expect if the children had been brought up by their ill, biologic parents.

What about the effectiveness of psychotherapy for less severely ill "neurotic" patients who visit psychiatrists, psychologists and social workers in their private offices or as out-patients in the psychiatric clinics and community health centers?

Each year, millions of Americans troubled by the vicissitude of life, or anxiety, or phobias, obsessions and depression visit these practitioners in the hope of emotional help. How effective is the treatment?

The professions have long congratulated themselves that they're doing an effective job. But increasingly in the last dozen years, research-oriented professionals have put psychotherapy to controlled scientific tests.

Dr. Norman Q. Brill, professor of psychiatry at UCLA—who, incidentally, believes somewhat in psychotherapy—divided the clinic patients into groups. One received psychotherapy, another was put on the waiting list, another was given sugar placebos, and the fourth was given minor tranquilizers such as librium.

The patients were evaluated before treatment and after, and Dr. Brill reported in the Archives of General Psychiatry that all groups improved at the same rate. Sugar pills and waiting had done as well as modern psychotherapy.

Waiting list studies at Kaiser Foundation Hospital in Oakland and the Crisis Intervention Center at University of California, Irvine, show the same result: that nonpsychotic patients improve as well with simple passage of time as with psychotherapy treatment.

Dr. Lester Luborsky at the University of Pennsylvania studied 166 research studies on psychotherapy and concluded that the type of therapy is of no significance; that the less sick patients, both physically and mentally, do better; that higher intelligence increases the chances of improvement; and that social achievement is also closely related to improvement.

Psychotherapy is hardly a scientific or medical technique if sugar pills and waiting lists do as well, and intelligence and social class determine the outcome.

Is one therapist better than another? Is professional training necessary for skill in the art of psychotherapy?

New studies indicate that untrained laymen actually do as well as the best psychotherapists nominated by their profession. At Vanderbilt University in Nashville, Tennessee, research psychologist Hans Strupp gave 15 psychiatric out-patients to five therapists nominated by the medical school and another matched 15 to 7 professors of English, history, math, and philosophy nominated by the students. The medical school evaluated the patients before and after treatment. What was the result? The liberal arts and science professors proved to do as well as the outstanding professional psychotherapists.

It is obvious to astute researchers and observers that psychotherapy is faith healing and a human relations activity, which like all social intercourse between human beings, can be beneficial, of no value, or harmful. In fact, a recent consensus of 150 psychotherapists indicate that one in ten patients are harmed by this supposedly benign technique.

The failure of psychotherapy and the scientific and medical neglect of the mentally ill by the profession is one of the great failings of American health professions. Much of the reason for this neglect is based on undue interest in the probably nonexistent psychological phenomenon first proposed by Sigmund Freud.

Fortunately, an increasing minority of the profession is fighting to correct this false balance. Dr. Robert Spitzer of Columbia Medical Center, heads an American Psychiatric Association commission to revise the profession's diagnostic manual. The new draft asks for the elimination of the term "neurosis" and deletes all psychological definitions of mental conditions. Dr. Alfred M. Freedman, Chairman of Psychiatry at New York Medical College, summed up increasing skepticism in the profession when he recently stated: "It is possible that Freudian theory may be proven no more scientific than astrology or phrenology."

In closing, I would ask the members of this Senate committee to use their best efforts to appropriate funds for medical and biological research in the treatment of mental illness and to understand that science is increasingly demonstrating that psychotherapy is not a proven medical or scientific activity. Instead, it is one that diverts the energies of the nation and the psychiatric and psychological professions away from the true problem of mental illness.

**Senator TALMADGE.** The next witness is Dr. Nicholas A. Cummings of California, president-elect, American Psychological Association, accompanied by Russell Bent, Ph. D. of Georgia, president of the Georgia Psychological Association; Joan Willens, Ph. D., of California, chair, Psychology Advisory Committee, Colorado Medicare Study; and Clarence J. Martin, executive director and general counsel, Association for the Advancement of Psychology.

Senator Cranston wanted to be present here to introduce our next witnesses, Dr. Willens and Dr. Cummings, but unfortunately he is unable to be here. He has asked me to express his disappointment and I ask that Senator Cranston's statement be printed in the hearing record at this point.

[The prepared statement of Hon. Alan Cranston follows:]

STATEMENT OF HON. ALAN CRANSTON, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Mr. Chairman, I am particularly delighted to have this opportunity to introduce Dr. Joan Willens. Dr. Willens is a leader in the field of psychology and has

worked with your committee and with the Department of Health, Education, and Welfare, in developing the demonstration project in Colorado that is evaluating the effect of covering psychologists as independent practitioners under medicare.

Dr. Willens will report to you on the findings of that project.

She has been a valued health-care advisor to me throughout my service in the Senate and I know her testimony will be very helpful.

I am also pleased that another outstanding Californian, Dr. Nicholas Cummings, president-elect of the American Psychological Association is testifying today also. I'm confident his testimony will make a valuable contribution to the hearing record also.

As a supporter since I have been in the Senate of amendments offered each Congress by my good friend, Senator Inouye, which would authorize reimbursement to clinical psychologists as independent practitioners, I am pleased that Dr. Willens and Dr. Cummings are speaking on behalf of that provision.

Once again this year, I have cosponsored S. 123, introduced by Senator Inouye.

This legislation would authorize the reimbursement of clinical psychologists as independent practitioners under medicare.

Mr. Chairman, although psychologists cannot treat patients with drugs, they can provide the counseling services which frequently are all that is needed to help individuals make necessary adjustments for continued functioning in society. Psychologists' fees are generally lower than psychiatrists'. Experience under the federal employees health benefits program has shown that direct reimbursement of psychologists has not resulted in major cost increases as had been feared.

Under current medicare law, as you know, psychologists can be reimbursed only for diagnostic tests when a patient is referred to them by a physician. This procedure places the psychologist, a reputable professional, in a secondary and inappropriately subordinate position, and seriously underutilizes the skills of a valuable member of the health care professions.

I hope your committee will study this issue carefully and will conclude that psychologists should be recognized as independent practitioners.

Senator TALMADGE. You may proceed, Dr. Cummings. Please restrict your remarks 10 minutes or less.

Mr. CUMMINGS. Thank you, Mr. Chairman.

**STATEMENT OF NICHOLAS A. CUMMINGS, PH. D., PRESIDENT-ELECT, AMERICAN PSYCHOLOGICAL ASSOCIATION, ACCOMPANIED BY RUSSELL BENT, PH. D., PRESIDENT, GEORGIA PSYCHOLOGICAL ASSOCIATION; JOAN WILLENS, PH. D., CHAIR, PSYCHOLOGY ADVISORY COMMITTEE, COLORADO MEDICARE STUDY, AND CLARENCE J. MARTIN, EXECUTIVE DIRECTOR AND GENERAL COUNSEL, ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY**

Mr. CUMMINGS. My name is Nicholas Cummings. I am a clinical psychologist in California and president-elect of the American Psychological Association. I am accompanied here today by Russell Bent, Ph. D., president of the Georgia Psychological Association. Dr. Bent is also vice chair of the National Advisory Panel to CHAMPUS. His work with other prominent psychologists has recently produced the APA-CHAMPUS out-patient psychological peer review manual which, we believe, will become a model for quality mental health care, economically rendered, and he will speak to these issues.

I am also accompanied by Joan Willens, Ph. D., a fellow Californian. Dr. Willens has been deeply involved in the Colorado medicare study which continued to study the utilization of psychological services under medicare, and she will speak to that issue.

I am also accompanied by Mr. Martin, our counsel.

Mr. Chairman, the mental health needs of our elderly are not being met under the present medicare system. There are far more elderly in public mental hospitals than should be. There are many others in nursing homes or under home health programs who are being kept overly medicated and untreated. In fact, the overmedication of the elderly is approaching a national disaster in our society:

Because medicare pays for medical care and hospitalization, there are many who are being treated for medical problems when other treatments would be more effective and less costly.

This kind of overutilization and misdirection of treatment is something with which I am familiar. It is analogous to the circumstances that led to the adoption at Kaiser-Permanente of a health plan with extensive mental health services.

For 18 years, Mr. Chairman, I was privileged to be chief psychologist at the Kaiser-Permanente Health Plan in northern California. Together with my colleague, William Follette, M.D., chief of psychiatry at the same institution, I have coauthored a number of studies there at Kaiser-Permanente. We have 16 years of followup with these studies, and some conclusions should be known to this committee and considered in determining mental health benefits under medicare.

Persons in emotional distress are significantly higher users of both inpatient and outpatient medical services. In fact, we learned in the late 1940's at Kaiser-Permanente that 60 percent of all the doctors' visits had nothing physically wrong with them, but were suffering from emotional distress. And, out of necessity, we provided mental health services because our physicians' visits, X-rays, laboratory tests, and drug treatments were rendering soaring costs because of elusive or unidentifiable physical problems.

When we instituted access to psychological treatment, we found significant declines in medical utilization in those emotionally distressed individuals who received psychotherapy, and those declines in medical utilization remained constant during the 5 years following the termination of psychotherapy by the treated patient.

We now have some 12 years' followup on our initial samples.

In summarizing our 16 years of prepaid mental health experience at Kaiser-Permanente, we concluded that there is no basis for the fear that an increased access to mental health services will financially endanger the system. It is not the number of referrals received that will drive up costs, but the manner in which services are delivered that determines optimal cost and therapeutic effectiveness.

We found that even one visit of psychotherapy, unexpectedly, reduced medical utilization by some 60 percent, and this remained constant over 5 years. Brief therapy reduced it by 75 percent.

We found that if brief psychotherapy is provided, it will be the choice by 85 percent of the patients. Ten percent need long-term therapy, but one can finance those who need long-term therapy by the fact that the majority of the patients receive effective short-term therapy.

These results, although impressive, would mean little if they had not been replicated in many studies all over the world. In fact, it was the investigation of the effects of psychotherapy on hospitalization in

West Germany that prompted the West German Government to include psychotherapy in their national health insurance.

Our work at Kaiser-Permanente has been replicated at Health Insurance Plan of New York, Group Health Association of Washington, D.C., and many other HMO type of institutions. I am happy to say that recent studies coming out of mental health institutions in California and in Dallas, Tex., demonstrate that psychotherapy provided to ethnic minority peoples on the poverty levels where psychotherapy is totally subsidized by public funds reduced medical utilization in these populations.

It is my contention, Mr. Chairman, a contention supported by substantial research data, that efficient and economical health delivery systems, whether under medicare or national health insurance, can only be developed by making available mental health benefits similar to that provided under Kaiser-Permanente.

On August 10, the Health Subcommittee of Ways and Means voted unanimously to recognize psychologists as independent practitioners under medicare in an inpatient setting. We hope this committee will recognize that the greatest benefit to be derived will be accomplished by extending eligibility in both inpatient and outpatient settings.

The cost estimates used by the Ways and Means Committee, supplied to them by the Office of HEW Actuary, estimates \$6 million for the first year cost of outpatient services. Mr. Chairman, that is not a cost, it is an investment, an investment in better mental health services which will pay dividends in the reduction of cost and more reasonable utilization of the medicaid system.

I thank you, Mr. Chairman, and I would like to call on Dr. Willens to speak regarding the Colorado study.

Ms. WILLENS. Thank you.

Mr. Chairman and members of the subcommittee, approximately 3 years ago the staff of the Senate Finance Committee conducted an experiment in Colorado to answer its concerns about including psychologists as independent practitioners under medicare. Some of those concerns were very basic, and others quite complex. But we have attempted to respond to your questions in the 1½ years that the study has been underway.

Let me briefly go over several of the questions that were raised in how psychology serves as one model in how our profession can function under medicare.

Question No. 1: Who is a psychologist?

Psychologists have a uniform standard that defines the training and experience necessary to function in the health care area. Although psychologists are statutorily recognized in all 50 States, State laws do not generally require specialty designations per se, nor are physicians, dentists, or lawyers licensed by specialty practice under their applicable State laws.

Psychologists in Colorado, and nationally, who practice independently must have achieved a doctoral level in psychology and, in addition, have 2 years of supervised postdoctoral experience. They must also be licensed by the State examining board.

In the Colorado experiment, a committee reviewed all applications for both training levels and the quality of their work experience.

Out of 190 applications at the start, 166 psychologists were certified.

In the first evaluation, Stanford Research Institute who was the independent evaluators of the experiment stated that this process has operated successfully.

Question No. 2: What should psychologists be doing, and how can you be assured that they are doing quality work?

In Colorado, we developed lists of covered and excluded services which have a general, national acceptance by the profession. Fringe and controversial therapies were excluded.

In our judgment, present psychiatric nomenclature is not a good indication of what a person's problems are, so claims forms were developed which require a practitioner to describe a problem and what he is actually doing about it. Providing assurance of quality work is complicated in mental health, and we have developed a workable system in Colorado. A peer review committee of psychologists examines all claims beyond 6 hours of therapy and 3 hours of assessment to determine what services are appropriate and, therefore, reimbursable.

Again, Stanford Research Institute states that this is working.

Question No. 3: Can psychologists establish proper medical collaboration when needed? One of the major components of clinical psychology training is in the area of diagnosis. We have been trained to consult, collaborate and refer, when necessary, the most appropriate health care providers. Psychology is also concerned about the issue of medication for the elderly, from several standpoints.

I have more that I would like to submit, but I see that the yellow light is on.

Senator TALMADGE. Your entire statement will be inserted in the record. Thank you for a very fine statement.

Ms. WILLENS. Excuse me. Also, we do have a statement to respond to Mr. Gross. We do not have the drama that he has, but we—

Senator TALMADGE. You may submit it, and it will be inserted in the record.

Ms. WILLENS. If I might, I would like to present Dr. Bent for a brief presentation.

Senator TALMADGE. Doctor?

Mr. BENT. Senator, the psychological association, together with CHAMPUS, has—is that the bell?

Senator TALMADGE. I hate to call time on you, but we are limited for time.

Mr. BENT. Let me make just one statement and enter something.

Senator MATSUNAGA. I yield 1 minute of my time to Dr. Bent.

Senator TALMADGE. Without objection, Doctor, you are recognized for 1 minute.

Mr. BENT. Particularly this is related to your initial statement—I will hand it to you—together with some CHAMPUS material.<sup>1</sup>

We feel that we have made a great deal of effort, and with success, to more objectively indicate what psychological services should be, what psychological services are rendered to clients, and to better describe—have clients better describe—with their practitioners what

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<sup>1</sup> Material referred to was made a part of the official committee file.

the results, or the outcomes, of therapy will be, and that we have a way of retaining the costs of utilization of that. And the project of the American Psychological Association with CHAMPUS, I will submit for your reading, to show such an objective system of cost containment and quality control.

Senator TALMADGE. Thank you very much, doctor.

How many different analytical theories and groups are there in the psychology profession?

Mr. CUMMINGS. Roughly, I would say, about 100.

Senator TALMADGE. What is jogging therapy?

Mr. CUMMINGS. I was not including that among the hundred, Senator.

Senator TALMADGE. What is poetry therapy?

Mr. CUMMINGS. What is poetry therapy? I have no idea, sir.

Senator TALMADGE. What is dance therapy?

Mr. CUMMINGS. I have no idea.

Senator TALMADGE. What is Z-therapy?

Mr. CUMMINGS. I have some familiarity with that. That is not what I am including in my hundred techniques.

Mr. BENT. All of these therapies, for example, would be excluded in the kinds of criteria we have set up, so they would not be allowable in the CHAMPUS program, or we would say they should not be allowable under medicare and medicaid.

Senator TALMADGE. To what extent are these modes of treatment utilized?

Mr. BENT. I would say very infrequently by members of the psychological profession, very infrequently.

Senator TALMADGE. How valid are these modes of treatment?

Mr. CUMMINGS. Quite questionable.

Ms. WILLENS. They get a lot of publicity.

Senator TALMADGE. In psychotherapy, what do psychiatrists do which clinical psychologists cannot do?

Mr. CUMMINGS. Electro-shock, psychosurgery, prescribing drugs, techniques such as that. Clinical psychologists do not perform those which are clearly medical techniques.

Senator TALMADGE. Senator Matsunaga?

Senator MATSUNAGA. Thank you, Mr. Chairman.

I feel a lot better after listening to your testimony and the tests which you spoke of, I think, tend to prove that even for physical illnesses, a little psychiatric or psychological treatment would definitely shorten the period of physical illnesses. I want to congratulate you on the excellence of your presentation.

Mr. CUMMINGS. Senator Matsunaga, if I may, because I heard one of my studies quoted, but I only heard half of it quoted, and I am a little bit put out, because I did two parts to this study and I only heard one part, the Kaiser-Permanente study on the waiting list.

It is true after 6 months that both the treated and the untreated patients demonstrated a diminution, or reduction, of anxiety, but when we followed up on what was happening to the untreated patients, we found that they had tripled their medical utilization, their hospitalization rate was twice the health plan average, so that yes, they were feeling better, but it was at the expense of physical illness.

Senator MATSUNAGA. I am glad you mentioned that.

Ms. WILLENS. Senator, may I also add, very briefly, that in the report that we are submitting, there is a study of 700 outcome studies of psychotherapies that were done, and in over 90 percent of them, the psychotherapy group benefitted more than the control group and there was no evidence of harm done to any of the remaining.

This is the widely acclaimed research that has taken place most recently.

Senator TALMADGE. Senator Laxalt?

Senator LAXALT. I just have an observation or two.

I might say that personally I have found it somewhat mystifying as to why this question has not previously been included. From the standpoint of my own experience, in my own State, particularly in the area of care for the elderly, I think that this profession has performed a badly needed service, and they have performed it well.

Since being here, I have had occasion to travel about the country. As a matter of fact, my own mother was involved in elderly care in California, and some of the most valuable services being rendered there was done on this level.

And it is my feeling that this type of proposal may be overdue, and we should give it very serious consideration; recognize that the criteria will necessarily have to be limited, and certainly none of you would quarrel with that premise, because we do have some strange expressions of the profession at times, as the Senator's questions would indicate.

But, Mr. Chairman, I do feel personally that this is something that this subcommittee should inquire into very extensively.

I thank you for your testimony. I thank all of you.

[The prepared statement of the preceding panel follows:]

STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION PRESENTED BY  
DR. NICHOLAS A. CUMMINGS, PH. D.

SUMMARY

The testimony of the American Psychological Association to the Subcommittee on Health of the Senate Finance Committee includes the following points:

1. The American Medicare-eligible population suffers an above average incidence of emotional and mental disorder, yet they are the most underserved group in terms of access to adequate and appropriate mental health services.

2. The present Medicare structure discriminates against and prevents the elderly person in need of mental health care from receiving those services in the most appropriate, cost-effective and treatment-efficient manner.

3. The present Medicare structure discriminates against and prevents the elderly person in need of mental health care from receiving benefits available to those eligible for other major federal health programs, such as CHAMPUS, FEHBA, etc.

The present Medicare structure discriminates against and prevents the elderly person in need of mental health care from access to 50 percent of qualified mental health practitioners, psychologists.

Psychologists are uniquely qualified through training and licensure requirements to deal with mental and emotional problems.

Psychologists can render a range of quality services under Medicare with constraints on both cost and utilization.

The cost of recognition of psychologists as independent providers of therapeutic services, eligible for direct Medicare reimbursement, has been proven by study after study to be more than offset by the corresponding reduction in utiliza-

tion of medical services; by elimination of the current expensive "physician supervision" requirement; by lower inpatient hospitalization charges; and, most importantly, by allowing the elderly consumer access to appropriate care.

We recommend, therefore, that qualified licensed psychologists should be recognized as direct providers of mental health services under Medicare as stated in S. 123, which is co-sponsored by three members of this subcommittee, and an additional 32 members of the Senate.

Mr. Chairman and members of the subcommittee: The need for mental health care by older Americans has been well documented in recent years. Of the 23 million older persons, the prevalence of mental disorders and emotional distress is higher than among the general population. It is estimated that up to 25 percent have significant mental health problems. Patients over age 65 occupy a staggering 30 percent of the public mental hospital. Further, approximately 50 percent of elderly patients in nursing homes are suffering from a significant degree of mental or emotional distress—and often without appropriate treatment. Yet, due to their inability to pay and the skewed coverage of Medicare, the elderly are rarely seen in outpatient clinics. It is reported for example, that only 4 percent of the patients seen in private psychiatric care are elderly.

Because Medicare pays for medical care and hospitalization, these are the types of treatment offered to Medicare recipients, regardless of the patient's actual treatment needs. The recent report of the President's Commission on Mental Health concludes that: "Discriminatory financing for ambulatory mental health services provides incentives for hospitalization and general physician services not designed for treatment of mental disorders. Yet studies have indicated that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than organic illness. If anything, current Medicare restrictions reward inappropriate services for mental and emotional distress." (Vol. II, p. 1128)

The very important message that must be gained from these statistics and conclusions is that people who suffer from mental and emotional disorders will seek out health care of some type if it is available. Since physician-directed and hospital-based services are available through Medicare—this is what Medicare-eligible patients use. All would agree, however, that inpatient care is the most expensive care and, for most emotional disorders, inpatient services do not generally provide the most efficient or effective mental health treatment. If the Medicare program can hope to reach its goal of providing for adequate health care at the reasonable cost, the system must be changed to allow greater reimbursement for outpatient mental health services.

The services that are being delivered—whether through inpatient or outpatient settings—must, of course, come from a practitioner who is properly trained and credentialed for those types of services. It is becoming clear from recent reports, however, that the health practitioners who are delivering and billing for mental health services may not always be adequately trained in mental health care. The current Social Security Administration-sponsored experimental study of Medicare benefits in one state, the Colorado Medicare Study, has given us some interesting and disturbing data on the kind of practitioners who are actually delivering mental health services. Preliminary reports from that study strongly suggest that the majority of reimbursement claims for mental health care come from general practice physicians—not from any kind of mental health specialist. An examination of the education and postgraduate training of general practice physicians will reveal that there are very few opportunities for training in behavioral science, and virtually no training in diagnosis or treatment of mental and emotional disorders. The President's Commission on Mental Health comments dramatically on this point:

"Available evidence supports the view that funding of somatic medical care currently pays for a significant amount of care for emotional or mental problems, even though they are not defined or reported as such. In such situations where the provider is not specifically trained to provide such services, the quality of care may be questioned and expenditures for such care may be misdirected and of questionable benefit." (Vol. II, pp. 512-513)

In contrast, the psychologist is specifically educated, appropriately trained, legally credentialed and widely recognized in federal, state and private health programs to deliver mental health services. In contrast to the Medicare program where psychologists may only deliver therapeutic services under the supervision of a physician, psychologists are recognized as independent providers of mental

health services in virtually every major federal health program—including CHAMPUS (The Civilian Health and Medical Program of the Uniformed Services), CHAMPVA (The Civilian Health and Medical Program of the Veterans Administration), and FEHBA (The Federal Employees Health Benefits Act). Psychologists are recognized in the Medicaid program. Psychologists are recognized in the HMO program. Psychologists are recognized in many private health insurance plans. Twenty-eight states and the District of Columbia have passed laws that mandate coverage of mental health services by psychologists in private health insurance plans. These "Freedom of Choice" laws, as we call them, now cover over 70 percent of the population in the United States. It simply does not make sense to exclude direct coverage of psychological services in Medicare when those services are so clearly needed, and when the profession of psychology has so well established and maintained its worth to the health care system.

The physician supervision requirement in Medicare was undoubtedly intended as a means to control the quality of health services and to help insure that mental health services were necessary and appropriate to the overall care of our elderly population. In practice, however, it is an impediment to efficiency, it is a direct contributor to inflation of health care costs, and it is a terrible hurdle in attempting to meet the mental health care needs of the Medicare population. In practice, a patient visits a physician, the physician refers the patient to a psychologist for therapy, and the physician sends the bill for services to the Medicare program. Under the current Medicare structure, the patient is not likely to receive psychological services unless he or she is also billed for a medical problem of some kind. In practice, the present system promotes increased costs, leads to inappropriate services, and forces health professionals to operate under a legislatively-mandated system of fee-splitting or double-billing.

One proposed rationale for the exclusion of psychologists from Medicare has been that psychologists cannot prescribe drugs. Although it is certainly true that psychologists do not promote the use of medication, and prefer the use of psychotherapy and other behavioral techniques to help their clients, it is not valid to say that psychologists are unfamiliar with the physical side of health. Psychologists have long recognized the interrelationship between physical health and mental health. We have pioneered in the use of behavioral treatment programs for many major physical problems. Physicians have consistently turned to psychologists to help them solve problems that drugs cannot treat. In an age where librium, valium and amphetamines are among the top five chemical substances abused in this country, psychopharmacological approaches to many emotional problems may do more harm than good. Certainly in the Medicare population, the problem of over-medication of patients is becoming severe. Too many of our elderly are burdened with massive numbers of pills, large and increasing costs for this medication, and a general lack of awareness of what each drug does, how each drug reacts with the next, and what they could do to avoid this total dependency on medication.

Certainly, medication is often very helpful to the treatment of an individual. In these cases, psychologists call on their medical colleagues the same way that a general practitioner calls on a specialist. Even though general practice physicians are licensed to deliver any medical service or prescribe any medication, they generally refer the patient to a specialist when a particular problem would be more appropriately handled by another health professional. In these cases, the psychologist requests the patient to see a physician for medication—and the physician and psychologist work together to monitor the patient's progress. This is a reasonable relationship between the professions, and one that recognizes the individual expertise of each. However, to suggest that all mental health care should be entrusted to physicians just because they can prescribe medication—and in spite of the fact that most non-psychiatrists do not have any demonstrable training or proven competency in psychotherapy—would be a foolish perversion of the presentable facts.

Years of research and practice have established the worth of psychotherapy in treating mental and emotional disorders. The research findings can be summarized in three points. First, psychotherapy works. Second, psychotherapy is cost-effective. Third, psychotherapy is beneficial not only to a person's mental health, but beneficial to a person's physical health as well.

Over the past 18 years, Dr. Nicholas Cummings has studied the effects of short-term and long-term psychotherapy within a large HMO—the Kaiser-Permanente Health Plan in San Francisco. With his psychiatrist colleague, Dr. Wil-

liam Follette, they attempted to determine whether the provision of psychotherapy in an HMO is associated with a reduction in the number of medical care visits, outpatient laboratory and X-ray procedures, and days of hospitalization. They found that making psychological services freely available to enrollees led to a very significant reduction in medical care utilization—and that this reduction was maintained for 5 years after the psychotherapy. Of this study group, about half received only one psychotherapy session, yet this group has a sustained reduction in medical utilization of 60 percent. About one quarter of the study group received from 2 to 8 psychotherapy sessions, and this group had a 5 year reduction in medical care utilization of 70 percent. The remainder of the study group stayed in therapy for more than 9 visits, and reduced their outpatient medical utilization by 51 percent, and their inpatient medical utilization by 86 percent.

This study, and the follow-up studies since, indicate that many individuals use medical services when they really need psychological services. Further, when psychotherapy is made available to patients, they do not over-utilize it. And very importantly, inclusion of psychotherapy within the Kaiser-Permanente Health Plan benefits saved money in the long run through reduction in the use of expensive medical, laboratory, X-ray and hospital services. The reduction in these utilization rates over a 5 year period shows that the medical complaints of these patients were, in fact, a way of expressing their emotional problems.

Although these results are certainly impressive, they would mean little if there were not other research studies that had similar findings. We would like to briefly summarize a number of other studies that support the effectiveness and cost-saving contribution of psychological services.

A study in the late 1950's in West Germany focused on the effects of psychotherapy on changes in utilization of hospital care. In their follow-up after five years, they found that there was a very significant reduction in hospital days per year for the treatment group, with no similar reduction for a control group.

A study in the 1960's at the Health Insurance Plan of New York examined the effects of psychotherapy on use of outpatient services. Information gathered a year before the psychological intervention showed that the study group represented consistently higher users of outpatient services. After psychological intervention, and for the 2 years following that were studied, there were uniform reductions in outpatient visits for family doctor services, specialist services and laboratory and X-ray services.

A study in the mid-60's at Group Health Association in Washington, D.C. reported the impact of short-term outpatient psychotherapy on utilization rates of physician services, and lab and X-ray services. The study group had a higher-than-normal frequency of physician visits before receiving psychotherapy and a lower-than-normal frequency of visits after. For the overall group, there was a 31 percent reduction in utilization of physician services, and a 30 percent reduction in lab and X-ray service visits.

The results from these and other studies over a period of many years indicates that people in psychological distress are significantly higher users of medical services. In most cases they waste medical resources with complaints of physical symptoms that are actually psychosomatic. Most importantly, when mental health services are made available to these people, they are able to benefit from them in both a psychological and medical way. Further, the information available on the low number of psychotherapy visits required to achieve and sustain the lower utilization rate makes the mental health benefit clearly cost-effective to the health care system—and personally effective to the individual in need of care.

There are two other projects about which the Committee should know. Both are efforts to develop working models for the delivery of mental health benefits. Both are highly cost-conscious. Both are concerned with efficient utilization review. Both are consumer oriented.

#### THE COLORADO CLINICAL PSYCHOLOGY/EXPANDED MENTAL HEALTH BENEFITS EXPERIMENT

Amendments to the 1972 Social Security Act made it possible for the Social Security Administration and the Department of Health, Education and Welfare to develop and operate experimental projects in order to test and evaluate new service delivery systems or combinations of existing health service and innova-

tive health therapy benefit packages. Upon the recommendation of the Senate Finance Committee, the Social Security Administration began work on a test project which already represents a major breakthrough in health care system management and design.

While the project deals primarily with psychological services under Medicare and their impact upon the overall quality of patient care and medical utilization, it has shown that questions regarding health care management which had been previously thought unanswerable can now be addressed in a system-like manner.

The Colorado Clinical Psychology/Expanded Mental Health Benefits Experiment carries implications that go far beyond mental health care. In designing the experiment, which now enters its second year of operation, government health planners, health planning consultants and psychologists developed (1) functioning mechanisms to assure the quality, appropriateness, and necessity of services, (2) procedures for the efficient and equitable determination of reasonable fees and reimbursement rates, and (3) a workable management framework to identify which services should be underwritten by the program and which services should not. Additionally, Medicare program representatives, health consultants, and the psychologists have reached a consensus regarding the identification of qualified providers eligible to participate in the project's service delivery system itself. Observers of the experiment, the first of its kind to be evaluated by the Department of Health, Education and Welfare, feel that it breaks new ground in integrating program design and the service delivery and management aspects of a health program.

The Process Evaluation Report recently released by the Department of Health, Education and Welfare, deals with the progress made in Colorado Experiment to date. Additional reports gained from the actual operation of the provider identification, delivery, and peer review components on the experiment, will become available in the future. We expect that the reports will be of major interest to the Department of Health, Education and Welfare and the Congress. The preliminary report is of immediate significance because it demonstrates clearly that management problems that had been thought to be insoluble regarding the totality of patient health care can be addressed in a responsible manner. We are particularly proud of the role played by psychologists in the design and administration of the experiment. In fact, psychology has played a pioneering role in the development of techniques of program evaluation and management based upon scientific knowledge. As the experiment enters its second year, it will be interesting to see how the actual psychological services themselves affect the overall effectiveness and utilization of Medicare benefits. For the present, it is exciting to know that the elderly in Colorado have access to an expanded range of benefits provided in the context of a workable quality assurance system.

#### PEER REVIEW FOR PSYCHOLOGISTS SERVICES UNDER CHAMPUS

Champus, the Civilian Health and Medical Program of the Uniformed Services, is the health and medical care program of the Department of Defense (DoD) for military retirees and dependents of uniformed personnel. The American Psychological Association (APA) has received a contract from DoD to initiate a program of peer review for psychologists providing outpatient services to Champus beneficiaries. The Project has two major goals: (1) to provide concrete criteria for psychological services to be used by first and second level claims review personnel and (2) to establish a network of psychologists to conduct third level review.

The APA Board of Directors appointed a National Advisory Panel to fulfill the contract terms. The Panel members are: Dr. Russell Bent, Deputy Superintendent of Georgia Mental Health Institute; Dr. Melvin Gravitz, independent clinical practitioner, Washington, D.C.; Dr. Anna Rosenberg, independent clinical practitioner, Baltimore, Maryland; Dr. George Stricker, Assistant Dean, Institute of Advanced Psychological Studies, Adelphi University; Dr. Joan Willens, independent clinical practitioner, Beverly Hills, California; and Dr. Harl Young, Professor, School of Professional Psychology, University of Denver.

The APA/Champus National Advisory Panel completed initial work on the Champus peer review criteria in December, 1977. The criteria are included in the APA/Champus Outpatient Psychological Claims Review Manual that APA will use in the training of reviewers and as an operations guide for the implementation of the peer review system in April, 1978.

The APA/Champus review system remains retrospective, meaning that actions taken in review are recommendations for approval, denial or partial approval of claims for mental health services provided. All claims for a beneficiary will be reviewed at the 8th, 24th, 40th and 60th session of treatment and at every 24th session thereafter. Providers submitting claims for treatment sessions reaching these points must also submit an APA/Champus Outpatient Psychological Treatment Report that should include definition of the patient problem, treatment goals, treatment to be provided, progress to date, and patient concurrence with the plan. Claims and treatment reports should be submitted to the local Champus agency by usual channels. Second level reviewers within the Champus agency determine if the services described in the claims' form and treatment report are within the limitations defined by the criteria. On the basis of the information supplied, the second level reviewers will recommend that the claims be approved for payment, denied for payment, approved for partial payment, or referred to three APA/Champus psychologist peer reviewers in the state where the claim originated. If referred for peer review, each of the three psychologist peer reviewers will examine the claim and treatment report and return them with individual recommendations to the second level reviewers. The second level reviewers will then complete disposition of the claim.

The APA/Champus Project will oversee the peer review system and abstract information about the claims referred for peer review. A data processing system will be developed to compile and monitor cases reviewed, reviewer characteristics, billing, and other basic information to track all claims reviewed by psychologists under the Project.

The APA/Champus National Advisory Panel selected 506 psychologists to serve as peer reviewers from among nominations by the presidents of state psychological associations and the chairs of state PSRCS. These reviewers were chosen on the basis of the diversity of their experience and current psychological practice. Although most nominees were qualified to serve as peer reviewers, the final selection required considerations such as expertise in specific treatment areas or testing and assessment, and geographic distribution in proportion to the number of Champus claims generated in each state. Of the peer reviewers selected, 97 percent have Doctorates in Psychology, 37 percent have significant Post-Doctoral training, 27 percent have been certified by the American Board of Professional Psychology in Clinical Psychology, 81 percent are listed in the National Register of Health Services Providers in Psychology, 96 percent are members of both the American Psychological Association and their state psychological association, 30 percent have some experience with peer review or professional standards review, and over 90 percent began psychological practice prior to 1970. Champus approved a list of peer reviewers on January 13, 1978 and nominees should receive notice of acceptance and letters of agreement in February 1978.

Mr. Chairman, the evidence we have synopsized here today all points to the same conclusion: that psychologists are professionals adequately, specifically and appropriately trained to provide needed mental health services. Psychotherapy works. Psychotherapy is cost-effective. Psychotherapy is beneficial to physical as well as mental health. After a full year of study, the President's Commission on Mental Health identified the Medicare population as among the most seriously underserved population in the area of mental health services. That the need exists for expanding the Medicare benefit in this area is no longer a question. We hope to have shown that psychology has reached sufficient professional maturity to provide these services independently of physician supervision, as with any specialist in the health professional field, and that psychologists can do so in a cost effective and quality controlled manner. We recommend that the subcommittee endorse the provisions of S.123 which would afford this recognition and make available to the elderly consumer access to services appropriate to their particular needs.

Senator TALMADGE. The next witness is Dr. Donald F. Klein, director of research, New York State Psychiatric Institute.

Dr. Klein, you may insert your full statement in the record and summarize it in not more than 10 minutes, please.

Dr. KLEIN. Thank you, sir.

STATEMENT OF DONALD F. KLEIN, M.C., DIRECTOR OF RESEARCH,  
NEW YORK STATE PSYCHIATRIC INSTITUTE

Dr. KLEIN. My name is Donald Klein. I am director of research for New York State Psychiatric Institute and professor of psychiatry at the Columbia University College of Physicians and Surgeons. I am thankful for the opportunity to present my views concerning the proper role for Federal financing of psychiatric care and my concerns with issues of cost containment and effective service. For the past 24 years, I have been engaged primarily in the scientific evaluation of differing methods of psychiatric care, including medication, psychotherapy, and hospitalization.

I have also had extensive opportunity to observe patient care at all levels.

Ideally, all health services should be based on a firm understanding of the different causes of various illnesses. Further, treatment practice should rest on scientific demonstration of safety and efficacy. The history of medicine is rife with treatment such as bleeding, purging, and leeches that were not only useless, but positively harmful. These treatments enjoyed abundant, enthusiastic testimonials from doctors and patients, as well as elaborate theories justifying their practice.

To become accepted, treatment should require more than the testimony of interested parties, whether they are well-meaning professionals who honestly believe that they are being helpful, or patients who wish to believe that they have been helped.

Mental disorders represent a special class of health concerns since, at present, we rarely know the cause of illness, although we have elaborate and conflicting speculative theories. Some progress has been made recently in our understanding of causation. This evidence shows that serious illnesses, such as schizophrenia, severe depression, and alcoholism have a substantial hereditary component. Unfortunately as yet, this knowledge has not helped us to develop new treatments.

Since we usually do not understand the causes of psychiatric disorders, we are, perforce, limited to an empirical approach to treatment. Given the situation, it is essential that methods of care be critically assessed so that we may winnow out the effective interventions from those that are only plausible or even evangelical.

To accomplish this goal, a new scientific methodology has developed over the past 30 years, the controlled clinical trial, which enables us to judge with comparative certainty how effective a treatment is.

Senator Matsunaga before questioned Mr. Gross about this. I would just make the point that in the comparison of treatments, you do not treat individuals, you treat groups, large groups of people who are comparable in status and randomly assigned to the different treatments. Under those circumstances, you can make very firm statements about the relative merits of different treatments.

The advance of the controlled clinical trial was largely prompted by the discovery of psychiatric medications which necessitated new reliable diagnostic techniques for the establishment of accurate prescription. The development of antipsychotics, antidepressants, anti-anxiety agents, and others, not only revolutionized treatment, but did

so in a manner unprecedented in the history of psychiatry. For the first time, treatment rested on facts, not on fads.

These new evaluative methods have been applied to other psychiatric treatments with surprising and often disturbing results. For instance, controlled studies of length of hospitalization have shown that prolonged intensive hospital care is no better than shorter care. Other studies have shown that, for many patients who are not a clear menace to themselves or others, partial hospitalization, such as day hospitals, may be more effective than full hospitalization, while being much cheaper.

When we turn our attention to the field of psychotherapy, we find that it has been very sparsely studied, despite the statements of the former witnesses, and that the few studies that have been done are often poor in quality. I am referring to studies of defined groups with severe mental illness.

A review of the best psychotherapy studies does not incite optimism, since most do not show beneficial effects, and at times even show harmful ones.

I would like to make the point, if I might divert from my writing, the previous witnesses made the point that the provision of psychotherapy decreased the utilization of medical services, and I think that very likely their facts are correct. But they did not deal with the issue of whether there was anything specific about the particular services given these patients.

It is quite conceivable that this was a variety of rent-a-friend type of treatment in which any sort of personal attention by a nontrained person would have had the same effect.

Initiating a program of Federal support for psychotherapy would be taking a great deal on faith and testimony, since proper scientific documentation is currently lacking. However, it is common belief among the psychiatric, psychological, and social work professions that patients benefit greatly from psychotherapy.

This area is of considerable importance. It is conceivable that, in deference to much professional opinion, Congress might allocate funds for time-limited forms of psychotherapy; of say, 20 sessions a year. Though this step would be a feasible social compromise, it would not speak to the crucial issues of efficacy.

The question would remain as to whether these funds were allocated to allow an effective treatment, or to placate professional groups and afford patients the illusion of effective care. I believe that, at present, the scientific evidence for psychotherapy efficacy cannot justify public support. Federal funds could best be used to develop and expand research programs in psychotherapy for well-diagnosed patient groups, rather than to perpetuate current practice. A focused 5- to 6-year research effort would provide much data that possibly would afford a basis for a reasonable conclusion concerning Federal support.

Another important problematic area in mental health care delivery is the movement toward community care and deinstitutionalization for patients with severe mental illness.

Unfortunately, the social mechanism for providing chronically ill psychiatric patients with adequate pharmacotherapy, guidance, social and vocational rehabilitation, housing, transportation, employment,

et cetera, has been very poorly conceived and funded. Effective liaison between welfare and health services is essential, and is largely nonexistent.

Even the provision for more narrowly-designed psychiatric care, such as in the community mental health centers, has been grossly defective. A properly run community mental health center requires a high level of psychiatric expertise, as well as staff devoted to rehabilitation. In fact, the salaries paid at most community health centers are not competitive with psychiatric private practice. Further, because of the limited resources provided, the conditions of work are often exasperating and demoralizing. Therefore, many community mental health centers have not had the psychiatric leadership or staffing required.

In an effort to make the best of a bad bargain, many such services have moved in the direction of a cheaper, nonmedical leadership for both diagnosis and prescription. In my view, this step has been a false economy. It has led to services which are, in the aggregate, both expensive and ineffective.

Further, such services have frequently relied upon such forms of psychosocial intervention as individual psychotherapy or paraprofessional guidance whose appropriateness has never been established and is very doubtful. There has been a desperate lack of self-critical assessment in the community mental health service movement.

This failure in self-assessment is now bearing bitter fruit, since the current general disillusion with these institutions may result in the dismantling of what was a partial inadequate move toward a positive social and medical goal. This is an area where Federal funds for psychiatric care, augmented by humane welfare regulations, allocated with a prior requirement for objective self-assessment of effectiveness, should have tremendous social and personal value.

Federal financing of such relatively limited, but socially crucial programs, would not break the bank.

Further, in terms of diagnosis, the most national cost-containment approach is to limit services to specific diagnoses where treatment-benefit can be expected, based on objective evidence. For such a limitation of funding to work, support for psychiatric evaluations is essential. This may be either outpatient or entail short-term diagnostic hospitalizations. Optimal psychiatric diagnosis requires extensive clinical experience with psychiatric patients. Also, since many physical illnesses produce mental and emotional symptoms the diagnostician must be medically trained.

Only well-trained psychiatrists approach this ideal. Other professionals do not have the breadth of clinical training necessary. This requires careful review, as to just what are the training programs for the variety of nonmedical professions. I think you will find them inadequate.

Unfortunately, even many physicians lack the background to do adequate psychiatric diagnosis and prescription of care.

To sum up, I recommend that Federal funding should be allocated: One, for psychiatric diagnostic services.

Two, for treatment of the patients with well-defined disorders such as schizophrenia, major depressive illness, severe anxiety states, et cetera. Such patients should be eligible for short-term or partial hospi-

talization, various forms of organic treatment, and the use of reimbursable ancillary psychosocial services.

For the chronically impaired, treatment should be available in self-assessing community services, with adequate psychiatric evaluation and prescription services to replace the current, amorphous, ineffective community mental health service model. Dovetailing with much better funded and directed human welfare services is essential.

For the very severely impaired who cannot maintain care for themselves, including many of our geriatric and chronic schizophrenic patients, support of humane family placement or high-level custodial facilities is required. In addition, given current knowledge, funding for psychotherapy as a primary form of care is premature. Further research may alter this state of affairs.

I have touched on many points using a broad brush, and I will be glad to elaborate in any way that you find helpful.

Senator TALMADGE. Doctor, to what extent can too much emphasis on mental health or mental illness in reliance on psychiatry and psychology create dependency rather than self-reliance?

Dr. KLEIN. I think it is important, Senator, to make a distinction between people who really have mental illnesses, diagnosable, severe mental illnesses, who require, if anything, more care because they are already made dependent by their illness. This is to be distinguished from the people who have the ordinary run-of-the-mill daily unhappinesses where reliance upon psychotherapy may actually be deleterious to them.

But this should not be used as an argument against the provision of such care for those people who really need it.

Senator TALMADGE. With respect to the diagnosis and treatment of mental illness, and based upon demonstrated scientific research and experience, what types of insurance coverage do you believe we can provide with reasonable confidence?

Dr. KLEIN. Well, I am not an expert in insurance coverage. I know something about psychiatry. My suggestion was that insurance coverage be limited diagnostically and be medically centered, and that the emphasis should be made upon institutional supplying of care, short-term hospitalization, and partial hospitalization as being very cost-effective methods of care, and the use of psychosocial services in an ancillary way—that is, not as primary service, but as indicated interventions once the correct, thoughtful medical psychiatric evaluation has been carried out.

Senator TALMADGE. How accurate are the diagnoses of mental illness?

Dr. KLEIN. That is a controversial and difficult area. Until quite recently, I would say they were extremely inaccurate. The vast majority of studies that were done concerning diagnosis showed low reliability. However, this has rapidly been improved in the past 10 years, largely due to the effort of a number of scientists based in St. Louis and in New York.

The finding was that if the conditions are well-defined so that people know just what they are talking about, then people agree with each other and can be very accurate in diagnosis. As long as you de-

pend upon vague definitions given in a sort of literary style, then the diagnosis are poor, but we are getting out of that

Senator TALMADGE. To what extent are people with physical difficulties being diagnosed erroneously as mentally ill?

Dr. KLEIN. I think that that is positively common. There are a number of studies indicating that—there is an excellent study that was done in England, for instance, at the Maudsley Hospital where a large number of patients were followed up who were diagnosed as "hysterical." A very substantial portion of those patients were demonstrated to have major medical disease on further followup.

I think it is essential that the psychiatric patient receive an adequately medically-informed workup.

Senator TALMADGE. Senator Matsunaga?

Senator MATSUNAGA. Thank you, Mr. Chairman.

Following up on the question posed by the chairman, is it not true that mental illnesses are frequently diagnosed as physical illnesses, and they subsequently are determined to have been mental in origin rather than physical?

Dr. KLEIN. I think that is a very good point. I think that is correct. It is not unusual for a patient to present a variety of physical symptoms where they have actually a psychiatric illness and there may often be an incorrect initial diagnosis.

Senator MATSUNAGA. Do you agree that there are illnesses which are purely psychosomatic in instances?

Dr. KLEIN. No; I am afraid I do not agree with that. I think that emotional factors may affect the course of diseases.

Senator MATSUNAGA. What is your definition of psychosomatic?

Dr. KLEIN. The term refers to distinct psychological conflicts, or are caused by psychological factors. I think that the evidences that such illnesses exist is minuscule. Psychological processes may effect the course of medical illness or may exacerbate medical illness. The evidence for that is quite good.

Senator MATSUNAGA. So frequently it would be necessary to treat the mental causes in order to get at the physical illnesses?

Dr. KLEIN. Frequently it would be necessary to give a person some form of psychosocial attention in addition to medication. I agree with that. The question is, what is the proper form of psychosocial attention? It may simply be the expression of continued interest upon the part of another human being and does not require any specific professional training.

That is a researchable question. It is not a question that we have to debate indefinitely. What you must do is take people who have comparable illnesses; some of them get one form of psychotherapy, some of them get another, and we see what the comparative outcome is. That is the sort of research that the Government should be supporting.

Senator MATSUNAGA. Are you a practicing M.D.?

Dr. KLEIN. Yes.

Senator MATSUNAGA. Have you ever sent your patients to psychologists?

Dr. KLEIN. For psychotherapy?

Senator MATSUNAGA. For whatever you do, for psychoanalysis, or—

Dr. KLEIN. I have recommended psychotherapy to many of my patients.

Senator MATSUNAGA. You have?

Were they sent to psychiatrists or psychologists?

Dr. KLEIN. It depended. If I thought that they had the sort of illness that required the use of medication, I would send them to a psychiatrist. Of course, that would simplify their care.

If I was convinced in my own mind, they had the sort of problem for which medication or medical evaluation was no longer relevant, then a psychologist might very well be the person to care for them.

But I would like to make a point. As a doctor, it is our duty to do everything that we think might possibly pay off for the patient. That does not mean that we always do things that we know are scientifically correct.

Senator MATSUNAGA. Well, you have clearly made the point that you, yourself, have recognized the need for the services of psychologists for some of your patients.

Dr. KLEIN. That is true, and the need for social workers and, for some of them, the need for friends.

Senator MATSUNAGA. You stated that studies are lacking—or, to the effect that there are no scientific studies to show the value of psychiatric evaluation and treatment. Did I understand you correctly? I lost the place that I had marked.

Let me withdraw that question, and ask you this instead. You stated on page 5 of your testimony that only well-trained psychiatrists approach the ideal of "optimal psychiatric diagnosis," and that other professionals do not have the breadth of clinical training necessary for proper diagnosis of mental illnesses.

This would seem to indicate that perhaps you do not include psychologists among those who you claim to have the breadth of clinical training necessary, and yet you have, yourself, referred your patients to psychologists.

Dr. KLEIN. After they have been seen by me. That is quite different from somebody else having the primary responsibility for evaluation and prescription.

Senator MATSUNAGA. I think elsewhere you did mention the lack of sufficient studies. As a matter of fact, you mentioned the fact that these were group studies and not individual studies, referring to a question that I had put earlier, to an earlier witness.

Now, you have heard the testimony of the earlier witnesses. Dr. Cummings, for example, who referred to studies done at Kaiser hospitals, done, again on the basis of groups. His study seemed to indicate rather conclusively that in fact psychiatric treatment or psychotherapy or whatever the term might be applied, did shorten the period of illness, even if such illnesses were diagnosed to be physical in nature.

Dr. KLEIN. Senator, I did not challenge the facts. I challenged the interpretation. It was, probably as stated, that these people required less medical care if they were given psychotherapy. But psychotherapy does not necessarily mean provision of care by a psychologist. It is conceivable that they would have gotten exactly the same effect if they had talked with a Boy Scout leader or if they had talked to somebody

who was completely untrained. That was not tested in that study, and that is the sort of testing that should be done.

Senator MATSUNAGA. But would you not concede that psychologists are better trained in the diagnosis and treatment of mental illnesses so that you would refer your patients to a psychologist, but not to a Boy Scout leader?

Dr. KLEIN. I would concede that I would do exactly that, but not that the Federal Government should support what is a desperate thing to do, which is to use a form of treatment for which the efficacy has not been specifically established.

If you remember, Mr. Gross, for instance, referred to the work of Dr. Strupp in which he compared psychiatrists, psychologists and people who were, you know, university professors in the efficacy of their attempting to help people and found, really, very little difference.

Now, I think it is possible—you must not misunderstand me—I think that psychotherapy is useful for many people. I can think specifically of patients who are phobic patients, patients with sexual difficulties, where I think there is considerable evidence that psychotherapy may be very useful to these people. I am also saying it is not established, and that before you go into the Federal funding of what will be a very costly treatment program, that you ought to fund the kind of research that will get you the answers.

If it were demonstrated, for instance, that the provision of psychotherapy by Ph. D's was specifically useful for the care of these patients, I would be all for it. They would have my entire support.

Senator MATSUNAGA. I have other questions, Mr. Chairman, but I do not wish to take too much time.

Senator TALMADGE. Do you want to submit them to the witness for response?

Senator MATSUNAGA. I may submit to you a few questions in writing, but time is fleeting by.

Senator TALMADGE. The responses will be placed in the record.

Dr. KLEIN. I would be delighted to.

Senator TALMADGE. Senator Laxalt?

Senator LAXALT. Doctor, just a question or two. Do I understand your testimony to the effect that you are closing the door entirely to psychologists, in terms of Federal funding?

Dr. KLEIN. No, I stated that there were severely ill patients who required the care prescribed by a psychiatrist, that this care often includes the provision of ancillary psychosocial services, in the current organization of care within institutions. Such ancillary psychosocial services are often provided by psychologists, social workers, occupational therapists, registered nurses, et cetera. All of those ancillary psychosocial services should be reimbursable, in my view.

Senator LAXALT. But under the direct supervision and control of psychiatrists. Is that your point?

Dr. KLEIN. That is my point.

Senator LAXALT. Do you see any framework under which the psychologists could function by themselves independent of the psychiatric profession?

Dr. KLEIN. I think that would be incorrect, as I understand things. Senator LAXALT. That is on the basis of insufficient data?

Dr. KLEIN. On the basis of insufficient data, and personal observation.

Senator LAXALT. It is true, is it not, that there are several States that have made this determination in favor of the psychologists in connection with medicaid?

Dr. KLEIN. I believe so, sir.

Senator LAXALT. How is that working in those States?

Dr. KLEIN. I do not believe it has been assessed; however, I would certainly be glad to try to review the facts, if they were available.

Senator MATSUNAGA. I did not hear that answer. Will you repeat that?

Dr. KLEIN. I say that I believe that has not been done. I do not personally know of any systematic assessment of effectiveness under those circumstances. Such a systematic assessment would have to be a comparative assessment in which similar patients are treated differently, and then the comparative outcomes are measured, and I do not believe that has been done.

Senator LAXALT. I gather, again, in getting at your testimony, that if we were able—and that would be a challenging task, I know—but with the data that is available in all of these various States and other data which you have presented to us, to build sufficient criteria so that the public and patient is protected, would you, under those circumstances, still have an objection to their operating on their own?

Dr. KLEIN. If convincing, scientific evidence was available that they were functioning effectively on their own, I not only would not object to it, I would support it.

Senator LAXALT. It would seem to me, from what little I know, that they could be very supportive in this whole field, and I would think, in recognizing the concern and anxiety your profession has, lest the whole field be usurped by a lot of people who are not qualified, otherwise it would seem to me, in a lot of these areas, particularly on the community level, that you would welcome this service.

Dr. KLEIN. I welcome any well-demonstrated service.

Senator LAXALT. Then that is the key, well demonstrated.

Senator MATSUNAGA. Would the Senator yield?

Senator LAXALT. Surely.

Senator MATSUNAGA. Is it not true that a large number of doctors who are not psychiatrists treat their patients for mental illnesses, and bill them for psychotherapy or psychotherapeutic treatment?

Dr. KLEIN. I believe that is true, yes, sir.

Senator MATSUNAGA. This would seem to indicate that perhaps even within the medical profession, which you represent, there are those who ought not to be practicing what they are practicing and refer their patients to better-trained psychologists. Is that not true?

Dr. KLEIN. I hardly represent the medical profession. I think they might have some feelings about that, also. I entirely agree with you. I was objecting to a particular form of treatment, no matter who it was done by.

Senator MATSUNAGA. One of the major objectives—Mr. Chairman, I am sorry to take this time. I should have asked the question earlier, but it bothers me a little—one of the major concerns of mine and Senator Inouye's in introducing the bills pending before this subcommittee was that the cost to the patient accelerates, or at least appears to accelerate, and we have found this to be true in Hawaii, when an M.D. refers a patient to a psychologist for treatment, and makes the charge of psychotherapy on his bill, for services rendered by psychologists. The bill is normally much higher than what the psychologists charged the doctor who referred the patient to the psychologist.

In Hawaii we have found—and I do not know whether you are cognizant of the fact that, in Hawaii, we do recognize psychologists as representing a profession which may practice independently of physicians; the cost of psychotherapeutic treatment has consequently been reduced since psychologists were recognized as independent mental health professionals.

Dr. KLEIN. Senator, I am sure you are correct in what you are telling me, but what I am focusing on is not so much the cost issues as the efficacy issues. If efficacy is not present, it does not matter what the cost is. You are wasting your money.

Senator MATSUNAGA. Well, whether you refer him to a psychologist or whether a patient goes directly to the psychologist, if it is the case of a need for pure treatment of a mental illness, I can only see increased costs when an M.D. refers the patient to a psychologist.

Dr. KLEIN. If you are saying that, given the choice of two useless things, you should buy the cheap one rather than the expensive one, I agree with you.

I am saying that so far, the efficacy has not been demonstrated.

I think I misspoke myself before when I said—I was referring to a kind of treatment to which I objected to. I did not mean that. I am referring to a kind of treatment for which Federal funding is questionable, not that the treatments themselves are objectionable, but they simply have not been demonstrated as effective.

Senator MATSUNAGA. Of course, when an M.D. refers a patient to a psychologist, the M.D.'s treatments, whatever he renders through others or by himself, would be payable through Federal funding, medicare or medicaid.

Dr. KLEIN. That is why I insisted, as the first point in my recommendations, that there be adequate funding for proper psychiatric diagnosis, because that is the proper gatekeeper for that sort of referral.

Senator MATSUNAGA. No further questions.

Senator TALMADGE. Thank you.

Thank you very much, doctor.

The next witness is Dr. James L. Cavanaugh, clinical director, Department of Psychiatry, Rush-Presbyterian-St. Lukes Medical Center, Chicago, and Dr. Roy Menninger, on behalf of the American Psychiatric Association.

We are delighted to have you, gentlemen. Please insert your full statement in the record and summarize in 10 minutes.

STATEMENT OF JAMES CAVANAUGH, M.D., CLINICAL DIRECTOR,  
DEPARTMENT OF PSYCHIATRY, RUSH-PRESBYTERIAN-ST.  
LUKES MEDICAL CENTER, CHICAGO, ILL., AND ROY MENNINGER,  
M.D., PRESIDENT, THE MENNINGER FOUNDATION, TOPEKA,  
KANS., ON BEHALF OF THE AMERICAN PSYCHIATRIC  
ASSOCIATION

Dr. CAVANAUGH. Mr. Chairman, the American Psychiatric Association, a medical specialty society representing over 24,000 psychiatrists nationwide, is pleased to testify before your subcommittee on the issue of mental health coverage under current Federal health care programs (including medicare and medicaid) and under any national health insurance program developed by Congress and the administration.

I am Dr. James Cavanaugh, clinical director of the Department of Psychiatry at Rush-Presbyterian-St. Lukes Medical Center in Chicago. With me is Dr. Roy Menninger, president, the Menninger Foundation, Topeka, Kans.

We welcome the opportunity to appear on behalf of our organization to share our views on insurance coverage for those in need of treatment for nervous, mental, or emotional disorders, both as now permitted under Federal law, and as may be developed in conjunction with a national health insurance plan.

Due to the stigma, fear, and misrepresentation of mental illness—a tragedy perpetuated by authors such as Gross, Szasz, and Ennis; the media, such as ABC's televised "Madness and Medicine"; and the conduct of everyday life itself—persons are reluctant to seek mental health services. Mentally ill persons are more likely than those with physical illnesses to delay or to reject early treatment. We are speaking of 20 to 32 million people who need mental health care. We are speaking of 2 million individuals who have been or would be diagnosed as schizophrenic; 2 million who suffer from profound depressive disorders; more than 1 million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. This is a large segment of our population to be left untreated, uncared for, and therefore not part of the working, contributing population that weaves the economic and social fabric of our Nation.

The stigma is heightened further because the discrimination has become institutionalized—written in the medicare law, written in the restrictive language for treatment of mental illness contained in most of the national health insurance bills now pending before this committee, and restrictive measures contained in most private health insurance plans. All suggest that mental illness is grossly different from physical illness—not treatable, not reversible, and not equally reimbursable when treatment is provided.

Such is now the case with medicare, the program to which I now turn attention, since it stands as a gross example of what a Federal health insurance program has done to assure mentally ill elderly Americans second-class citizenship compared to that provided to them for other health care. I am speaking specifically of the restrictions imposed under both parts A and B which arbitrarily reduce the benefit

for mental health treatment below those benefits provided for the balance of medical care. Part A limits lifetime inpatient benefits to 190 days, and part B limits annual outpatient coverage for mental illness to \$250 per year (resulting from a \$500 ceiling and a 50-percent copayment)—including ancillary medical services.

The mentally ill elderly are stigmatized thrice—once by the fact of old age, once by the fact of mental illness, and once by the fact that treatment is too costly beyond the limited benefits of medicare.

In 1971, the American Psychiatric Association Task Force on Aging, established to report on critical mental health issues identified by the 1971 White House Conference on Aging, pointed out that progress made during the previous two decades had been minimal. Among the reasons cited were the growth in number of the aging population, the recognition that their diversified needs may require diversified services, and that medicare did not provide sufficient benefits to allow adequate reimbursement for the treatment of nervous, mental, or emotional disorders.

In "Aging and Mental Health," Dr. Robert Butler, head of the National Institute on Aging, pointed out that:

Medicare coverage for psychiatric disorders is unrealistically limited and was inserted as a kind of afterthought. \* \* \* The system obviously affords inadequate coverage.

The benefits of expanded mental health coverage under medicare are many. Too often the elderly are told, and many believe, that adverse psychological symptoms are natural aspects of growing old. Senility is a term loosely applied to thousands of older Americans, yet as the President's Commission on Mental Health noted, "as many as 20 to 30 percent of those so labeled have specified conditions that can be diagnosed, treated and often reversed." As such, medicare costs would be ultimately reduced, and those individuals with reversible conditions would be able to become more productive, contributing and independent members of society.

Elimination of the discriminatory caps on medicare as proposed by Senator Case and endorsed by the APA, would have other effects. As Senator Case pointed out when he introduced the Medicare Mental Illness Non-Discrimination Act:

Elimination of the 50-50 copayment and enactment of the standard 80-20 copayment now used for physical health care will go a long way to ease the large cost burden imposed on those in need of mental health services.

Elimination of the 190-day lifetime limit for inpatient psychiatric care and substituting the "spell of illness" definition employed for the rest of medical care will result in greater attention being paid to appropriate placement in proper facilities for those in need of mental treatment as inpatients.

Elimination of the annual \$250 ceiling on outpatient treatment for mental, nervous or emotional disorders will result in greater utilization of outpatient services.

Moreover, it is essential to recognize that adequate, cost-effective mental health services can have the effect of lowering the cost of other health care services by as much as 50 percent for the average patient. This is evidenced in a growing number of studies.

One: In Texas, a longitudinal study (1973-1977) demonstrated that access to needed treatment for mental illness resulted in a reduc-

tion in mean length of stay of the over-65 patient in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than \$1.1 million.

Two: Group Health Association of Washington indicated that patients treated by mental health providers reduced their nonpsychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and X-ray services declined by 29.8 percent.

Three: Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of \$250 per year.

Four: Blue Cross of western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from \$16.47 to \$7.06, and overall costs were reduced by 31 percent, even when the cost of mental health treatment was factored in.

The cost of such legislation proposed by Senator Case—\$45 million—is fiscally responsible. The cost developed by the Social Security Administration, and borne out by the report of the President's Commission on Mental Health, does not reflect the savings to be realized from anticipated lower hospitalization expenditures or the substitution for existing part B expenditures. As noted in the Texas study, if the \$1.1 million savings were extrapolated to the entire medicare population in need of mental health care, the effect could be a significant lowering of overall medicare costs.

One of the mandates of the Older American Act of 1965, recently reauthorized by both the House and Senate and now awaiting conference, is to assure independence and dignity to this Nation's elderly population. A major step in that direction would be taken by ending arbitrary discrimination against the mentally ill elderly who are doubly damned by the stigmas of age and mental illness.

Before concluding, it is important to point out that a major issue raised whenever mental health insurance coverage is considered is that of direct reimbursement to other mental health professionals and paraprofessionals who treat individuals with nervous, mental or emotional disorders. We cannot fully support direct reimbursement to other mental health professionals, unless their disorders are defined carefully or, alternatively unless the Congress would authorize the provision of medically necessary or other supportive human services in treating nervous, mental or emotional disorders.

We believe that if direct reimbursement for other mental health care providers is to be considered, it is to be done so with clear specificity for the circumstances surrounding nervous, mental or emotional disorders, which authorize differences for collaborative or individual independent responsibilities.

We are hopeful, Mr. Chairman, that you will give careful consideration to the serious and unmet needs of those requiring treatment for

nervous, mental or emotional disorders, and that you will implement the recommendations of the President's Commission on Mental Health and those made almost 10 years ago by the White House Conference on Aging concerning future directions in mental health care both now and during serious consideration of a national health insurance program for our entire Nation.

Thank you.

Senator MATSUNAGA. Thank you, Dr. Cavanaugh.

Any questions, Senator Dole?

Dr. Menninger, do you have a statement?

Dr. MENNINGER. I had some comments to make, unless there is no time, in which case I will submit them in writing.

Senator MATSUNAGA. You may proceed. Can you do it in 3 minutes or 5?

Dr. MENNINGER. I will surely try.

I wish to speak to an issue which is not directly addressed, and that has to do with the definition of quality. My concern is that in any program of mandated care, there is a tendency to lump everybody together and then have to use rather formal definitions for what treatment will be prescribed. In other words, a patient with diagnosis  $\alpha$  should get treatment by electric shock 8 times in 21 days hospitalization.

Of great concern to me is the tendency to ignore individual differences. My testimony, sir, provides some definitions of quality other than that. I have offered one, in particular, that quality is a function of putting together three things: What the problem is, what the outcome should be, and what the approach should be.

It seems to me that to try to address all three of these with a simple definition of diagnosis will do a great injustice to a great many patients. The problem, therefore, is how to determine, within reasonable measures, what this goodness of fit might be. Here I rely very heavily on the concept of peer review.

I would urge that any system for mandated care put considerable emphasis on colleagues working together to define the quality of treatment, the course of treatment, the duration of treatment, and the adequacy of treatment. It is, parenthetically, for this reason, that the Mayo Clinic in Topeka exists. We have the firm belief that a collection of colleagues, psychologists, social workers, nurses, as well as physicians and others, are required to provide adequate treatment for very complicated psychiatric problems.

Our position would be that it is this kind of groupings of colleagues, in effect the creation of a team committed to the care of the patient, that will do the best job toward determining and then maintaining a level of quality that will truly address the nature of the patient's problem.

I would urge, therefore, that some thought be given to the use of the kind of definition of quality I have proposed and second, heavy reliance be placed on a peer review system in order that the best of necessarily imperfect knowledge be brought to bear on the many problems with which we are confronted.

Thank you.

Senator MATSUNAGA. Senator Dole?

**Senator DOLE.** Do I understand the cost, the estimated cost, of Senator Case's proposal is \$45 million?

**Dr. CAVANAUGH.** That is my understanding, Senator.

**Senator DOLE.** That is the cost developed by the Social Security Administration?

**Dr. CAVANAUGH.** That is true.

**Senator DOLE.** I was not certain, from your statement. I probably should know but, in addition, what about those from zero to medicare age? What is available for those under 21 and those from 21 to 65 or 62, or those who are totally disabled?

**Dr. CAVANAUGH.** In terms of mental health care benefits, it is quite a scattered picture, but similar in that most policies provided for them are deficient for mental health care services, with one possible exception, inpatient care benefits.

By and large, State-based plans, third-party carrier plans, Federal plans, on a consistent basis, discriminate against the mentally ill by not providing comparable, comprehensive mental health care services in comparison to care for physical illnesses.

**Senator DOLE.** Is it true that the vast majority of psychiatrists in the Nation's and State mental hospitals are foreign-trained and have not passed the State licensing exams?

**Dr. CAVANAUGH.** There is a percentage of individual physicians, both foreign medical graduates and others, who are practicing in State hospitals, many of whom are not psychiatrists. In other words, they have not been trained as psychiatrists and, in fact, are operating as general medical officers acting as physicians in the State medical system that have not met some of those requirements that you have alluded to.

I do not have available the exact numbers, but I would be happy to provide that information to you at a later date.

[The following was subsequently supplied for the record:]

AMERICAN PSYCHIATRIC ASSOCIATION,  
Washington, D.C., September 21, 1978.

Hon. HERMAN TALMADGE,  
*Chairman, Health Subcommittee, Senate Finance Committee,*  
*U.S. Senate, Washington, D.C.*

DEAR SENATOR TALMADGE: During the course of the American Psychiatric Association testimony at your Subcommittee hearing regarding mental health coverage under Medicare, Medicaid and any future nation health insurance program, Senator Dole requested information about the numbers of non-licensed Foreign Medical Graduates (FMG's) serving in state and local mental hospitals, and we are pleased to submit the following response.

According to a report entitled "Psychiatry and Mental Health Manpower," submitted by APA Vice President Donald G. Langsley, M.D., to the President's Commission on Mental Health, over fifty percent of psychiatrists in state and county mental hospitals are Foreign Medical Graduates.

State mental hospitals have consistently had difficulty in recruiting qualified psychiatrists. A 1976 telephone survey confirmed the shortages of psychiatrists in state hospitals and found that those hospitals with residency training programs (particularly those affiliated with universities) employed significantly more psychiatrists. Nine states which employed more psychiatrists and had significantly smaller proportions of FMGs were those which had residency training programs with university affiliations (Knesper, D. J.; University of Michigan).

Nevertheless, state hospitals are still highly dependent upon FMGs, including those who are not licensed. A telephone survey in August, 1977, of all states

(43 reporting) revealed that of all psychiatrists in practice in state mental hospitals, 13 percent are FMG's who are unlicensed in the state in which they practice, and another 17 percent are FMG's in residency training. Moreover, since state hospitals cannot recruit enough psychiatrists, they often also staff with physicians who are not psychiatrists. Of those physicians, 24 percent are FMG's who are unlicensed in the state in which they practice.

Thus, of a total of 5,592 persons, including psychiatrists, residents and other physicians in state mental hospitals, 27.5 percent are FMG's who are unlicensed.

We trust this information is responsive to the question presented at the hearing. Should the Committee require additional information, we would be pleased to be of assistance.

With best wishes,  
Sincerely,

**JAY B. CUTLER,**  
*Special Counsel and Director,*  
*Government Relations.*

Senator DOLE. On behavioral concerns, do you have any opinion on that?

Do you agree with that, or disagree with that?

Dr. CAVANAUGH. Could you restate the question, please?

Senator DOLE. It has been alleged that there have been far too many prescriptions written for mental illness or behavioral concerns.

Dr. CAVANAUGH. I think there certainly are a wide spectrum of illnesses for which appropriate medications are prescribed, and are effective. However, we do note that in this country there is overutilization of many of what are called psychoactive drugs, minor tranquilizers, and of course, one would not want to leave out alcohol which is probably the most abused substance of all.

So that clearly, in my opinion, your statement is an accurate statement.

Dr. MENNINGER. Senator, if I may add to that response, it is alleged that the largest single prescription of available drugs is for librium and those drugs related to it, and the largest proportion of those prescriptions are not written by psychiatrists but by general physicians.

I think, rather than simply noting that they are writing too many, it might be appropriate to ask why that is so. Certainly part of the problem is that a large portion of the patients who come to them for ostensibly medical difficulties are actually struggling with psychiatric problems or psychiatric disturbances which they cannot handle.

Unfortunately, many of the physicians cannot handle them either, so they use the medication as a stopgap. The answer to that might be to make more kinds of psychological and psychiatric experiences available to a broader range of physicians.

Senator DOLE. Is there any limit on what we should be covering at this time? Are there some obvious methods and theories of diagnosis and treatment that we should avoid covering at this time?

Dr. CAVANAUGH. I think that we should be emphasizing the coverage of major psychiatric illness, the major diagnosis including schizophrenic disorders, major affective disorders that are referred to as the most serious psychoneurotic disorders, and a rather broad spectrum of disorders in which physiological dysfunctions do appear to be related to psychological problems that an individual may be experiencing.

I would opt for a predominant emphasis on major psychiatric illness coverage in any health insurance plan. As stated earlier, there

really is quite a deficiency of outpatient benefit coverage for even the most serious types of psychiatric illness. There is better coverage on an inpatient basis.

Of course, while this does seem quite clearly to raise the overall cost of health care, there are studies being developed, as I alluded to in the testimony, that demonstrate that when ambulatory outpatient psychiatric benefits are provided overall health care expenditures can be reduced.

**Senator DOLE.** In followup to that, maybe Dr. Menninger might comment on the success you are having, and others, in getting people out of institutions into the outpatient area.

**Dr. MENNINGER.** I would confirm that and what Dr. Cavanaugh has just mentioned. One of the most serious problems with today's insurance coverage is that it puts a premium on hospitalization. I happen to believe that there is an important role for hospitalization for certain seriously ill patients, and I am very much aware that sometimes the only way that you can make that evaluation is to admit the patient for diagnostic evaluation.

However, most insurance coverage will not cover an evaluative procedure. Therefore, patients will be admitted to a hospital, thereby raising the cost for a procedure that could be done prior to admission and perhaps make hospitalization unnecessary. There is a similar problem at the other end. That is, it would be well if coverage could be made available for partial hospitalization so we could more readily substitute less expensive forms of hospital care by keeping the patient in treatment, but not having to pay the residential costs that are also part of full-time hospitalization. Part-time hospitalization would enable us to carry on treatment but to have the patient live at home or in a much more inexpensive setting.

As it is, neither is presently available—evaluation or partial hospitalization.

**Senator DOLE.** Finally, is there a role for community health centers?

**Dr. MENNINGER.** Absolutely.

**Senator DOLE.** Is the record there, the evidence there?

**Dr. MENNINGER.** The community mental health system has had a great deal of difficulty. It was inspired by enthusiasm, not buttressed by as many facts as were needed, but I am quite sure that there is an important role. My emphasis would tend to be away from the solo practitioner and towards those practitioners working together in groups.

Psychiatry and the issue of mental illness are too complicated to assume that one person has all the answers. We rely very heavily on the services of the members of a team. Unless you can put together a team, I do not believe that you can be as confident about the quality of care as otherwise.

**Dr. CAVANAUGH.** I believe the American Psychiatric Association would want, as I believe the Federal Government now is, to take a closer look at the cost-effectiveness of the community mental health center movement. Clearly, there are many stories of both great success and great failure within the system.

Organized psychiatry is concerned about the general trend toward deprofessionalization that seems to be occurring in some of the major

mental health centers in the United States. We are concerned, but in no way, should that be interpreted as meaning that organized psychiatry is opposed to the community mental health center concept.

Rather, we want to participate in taking a close look at its cost effectiveness and how the costs are being translated into help for the mentally ill clients who are going to such centers.

Senator DOLE. I would like to say, finally, I have requested a study of the community mental health centers, and hope to have that from HEW sometime soon.

Thank you.

Dr. CAVANAUGH. If I may, our staff did provide me with the answer to the question about the percentage of foreign medical graduates in the State mental hospital system. Our figures indicate that approximately 50 percent of the State mental hospital staffs are foreign medical graduates.

I want to emphasize the point that I made earlier that those foreign medical graduates in the State mental hospital system are not all practicing psychiatrists. Many of them are practicing general medical officers taking care of the physical needs of the mentally ill patients in the system.

Senator DOLE. Thank you.

Senator MATSUNAGA. Dr. Cavanaugh, if a patient appears to have a somatic problem, such as an ulcer, would a psychiatrist typically attempt to treat this problem, or refer him to another medical specialist?

Dr. CAVANAUGH. In the process of evaluation of that patient, if the suspicion were high that an ulcer were present, certainly a competent psychiatrist would refer him to a colleague.

Senator MATSUNAGA. Is it a general feeling among practicing psychiatrists that they are overloaded with work, too many patients, so that they are unable to provide the necessary time to any one patient?

Dr. CAVANAUGH. That is an interesting question. I certainly would not want to speak for all psychiatrists. If I can use my own example, my own practice, I think I am very busy, do a lot of work, but I can usually handle what is before me.

Certainly, one hears the concerned voice of psychiatrists who are overworked or feel they cannot take care of everyone they would like to. I would imagine that is a common complaint for many concerned people, not just psychiatrists.

Senator MATSUNAGA. I was leading to my next question because I have frequently heard that psychiatrists are overworked. Do you, as a psychiatrist, know of other psychiatrists in your association, who, because of being overloaded with work, or because they think that the nature of the illness is such that it can be better performed by a psychologist, refer such patients to psychologists?

Dr. CAVANAUGH. I have done that myself. Again, referring back to some of Dr. Klein's testimony, I believe that, upon appropriate evaluation, diagnosis of a given patient, depending on their particular needs, I think it is well within the limits of accepted medical practice to refer, if it is a mental illness, to a psychologist; if it is physical illness, to another physician or a physician assistant.

It depends on the nature of the properly identified diagnoses, and categorized matching of patient needs with the level of professional care required.

Senator MATSUNAGA. What about psychiatric nurses? Have you in your own experience referred any of your patients to any psychiatric nurses?

Dr. CAVANAUGH. I have not. I am from the State of Illinois. I am aware that there are psychiatric nurses who are doing the private practice of mental health care in my community and I am sure that patients are being referred to them from some source. I would have to assume that one of those sources might be my colleagues.

I personally have never had that particular opportunity.

Dr. MENNINGER. This is a practice that we utilize at the Menninger Foundation. I should point out that, once again, in the context of colleagues working together, not in reference to solo individuals.

Senator MATSUNAGA. Would you have any objection to the recognition of psychologists and psychiatric nurses, assuming that they were trained in the same practice mode, as independent mental health professionals? That is, when it is deemed necessary, and whenever a patient requires the services of a physician or a psychiatrist, would you object to those patients being directly referred to the other mental health professionals?

Dr. MENNINGER. Senator, are you referring to practitioners within the context of a group practice of some kind, or are you referring to these persons generally, without regard to whether they are in group or individual practice?

Senator MATSUNAGA. I am referring to the psychologists and psychiatric nurses who would be, by change of law, recognized as independent practitioners and be authorized to bill their patients directly.

Dr. MENNINGER. My feelings about that are quite mixed. I know very well that there are a great many superb practitioners within the nursing psychiatry-social work ranks. I do know that not all of the people I know who are psychologists are competent practitioners. I have difficulty making the judgment on the basis of discipline, but more in terms of the kind of training they have had, and if they are working with colleagues that provide the kind of peer review process for the kind of quality control I referred to earlier for blanket, across-the-board, with no basis for knowing about the qualifications, I would have trouble with that.

Senator MATSUNAGA. They would, of course, be required to be licensed by the recommendation of the duly constituted board of examiners, as we do in Hawaii. You would not have any objection then?

Dr. MENNINGER. I would have to think about that for a moment.

Dr. CAVANAUGH. Senator, if I might take a shot at that question. I believe the American Psychiatric Association would have some trouble with that, as I stated in the testimony, unless the area of practice under discussion, is clearly specified and what the limits are therein.

Frankly, in my opinion, careful attention to what is called the triage aspect, how the individual gets into the system is crucial. I believe, as an individual, and the American Psychiatric Association would also support this, that the point of entry into the health care system should be through a physician. Once the evaluation, at the

top of the pyramid, so to speak, has been completed, there are multiple options as to the appropriate locus for treatment.

We are concerned about the concept of totally parallel independent practice, because it can bypass the general health care system as it is presently designed. We are particularly concerned that the intimate relationship between psychiatric illness and physical illness might be overlooked or not paid attention to properly.

Senator MATSUNAGA. When you speak of point of entry being a physician, are you referring to a physician who is a psychiatrist?

Dr. CAVANAUGH. I realize that in an ideal world, the ideal system would place the psychiatrist per se in such position there are not sufficient psychiatrists to provide this kind of care. That would be the ideal situation, nonetheless.

I might add that we do need to train more psychiatrists. We do need to have more Federal money being delivered through the appropriate Federal agencies to augment the training of appropriate psychiatric specialists.

Senator MATSUNAGA. What bothers me about your proposition is that you assume that a physician without any psychiatric training or psychological training would be better qualified to prescribe treatment than a trained psychologist or psychiatric nurse, even if the illness happened to be purely mental in nature.

Dr. CAVANAUGH. I think that your comment has merit. I would point out, however, that increasing emphasis is being placed, at many levels of medical education, to make graduates of medical colleges more and more aware of psychological problems.

I do not have any difficulty with the concept of referral of a patient after appropriate medical screening to a mental health professional other than a psychiatrist. Again, it means that, at the point of entry into the health care system, there is an individual who can take a comprehensive overview of the physiologic and psychiatric state of the patient.

Dr. MENNINGER. Senator, I would like to suggest an idea that I have not examined closely enough to know whether it is fully worth pursuing.

If it is true that we can, generally speaking, provide more comprehensive and adequate treatment when working together as groups, perhaps there should be some sort of incremental economic incentive to encourage practitioners to work together in clinics, in HMO's in collegial relationships, to improve quality and thereby also deal with the very knotty problem of psychologists, social workers, nurses, and physicians working together.

It seems to me if all mental health professionals and paraprofessionals are all out there independent and fighting with each other, it comes down to a simple question of economics. Perhaps the incentive should be put less on promoting individual solo activities and more on encouraging collegial relationships, groups, HMO's, clinics, et cetera.

Senator MATSUNAGA. As I understand it, social workers and psychiatric nurses presently work on a salary basis out of an organized setting. Assuming that they are paid on a fee-for-service basis, would this constitute higher cost in your opinion?

Dr. CAVANAUGH. I think that what would happen, the team concept that Dr. Menninger is talking about, which historically has been the way that many mental health services have been organized, would continue to disintegrate. You would be left, as he was saying, with competitive, parallel professionals competing for turf, competing for the mental health part of the health care dollar. I could only guess that the fee-for-service approach would probably drive the cost up. I really think there is some evidence to suggest that in a comprehensive, organized health care setting, that general health care costs and mental health care costs, go down.

Senator MATSUNAGA. One of the concerns, as I expressed earlier—I believe you were in the audience then—as one of the introducers of the measures before this subcommittee to place psychologists and the psychiatric nurses under medicare-medicaid as an independent profession, or independent professions, I should say, was to keep costs down. Presently, as has been admitted and shown time and time again, whenever the point of entry is a physician, his own charges for deferring his patients are added on to the fee charged the physician by the psychologist or by the psychiatric nurse.

Dr. CAVANAUGH. There is a simple answer—that is illegal. If an individual should do that, he is eligible for prosecution, either at the state or Federal level.

If a psychiatrist refers a patient to a psychologist and takes a cut, that is fee splitting and it is against the Canons of Ethics of the American Medical Association, and those of the American Psychiatric Association. One has a legal remedy to that.

Senator MATSUNAGA. Of course, you know as well as I do that that can be readily covered by increased physician fees.

Dr. CAVANAUGH. I am sure that there are ways to get around anything. As a spokesperson for the American Psychiatric Association, I must say we are opposed to that, feel that that is contrary to our code of ethics and do not support it.

Senator MATSUNAGA. I realize that, and I commend you for it, but if we eliminate the referral process and permit the patients to go directly to a psychologist or psychiatric nurse, we do not need to worry about subterfuge.

Dr. CAVANAUGH. As I indicated earlier, it is possible to make that kind of referral arrangement without the kickback concept which, I believe, is illegal. I believe it is currently going on, that honest competent psychiatrists refer to nonpsychiatric mental health professionals without the surrounding kinds of illegalities that you are referring to.

I am aware, as you said, that illegal activities do go on. I totally disagree with such practices. I think it is illegal. As an organization, the APA is on record as opposed to that.

Senator MATSUNAGA. Thank you very much.

Senator DOLE. I just have one more question.

I asked earlier about prescriptions. Psychologists do write prescriptions?

Dr. CAVANAUGH. Yes, sir.

Senator DOLE. Do you generally use the person's name?

Dr. CAVANAUGH. Of course.

**Senator DOLE.** If we are concerned about openness and things of this kind, which we discuss here frequently, is it an accepted practice to put somebody else's or a fictitious name?

**Dr. CAVANAUGH.** It is unacceptable.

**Senator DOLE.** There is a little local story here that maybe has not gotten out—

**Dr. CAVANAUGH.** It has filtered into Chicago.

**Dr. MENNINGER.** But not Kansas.

**Senator DOLE.** Thank you.

**Senator MATSUNAGA.** Thank you very much.

[The prepared statement of Dr. Cavanaugh follows:]

**STATEMENT OF DR. JAMES L. CAVANAUGH, AMERICAN PSYCHIATRIC ASSOCIATION**

Mr. Chairman, the American Psychiatric Association, a medical specialty society representing over 24,000 psychiatrists nationwide, is pleased to testify before your Committee on the issue of mental health coverage under current Federal health care programs and under any national health insurance program developed by Congress and the Administration.

I am Dr. James Cavanaugh, Clinical Director of the Department of Psychiatry at Rush-Presbyterian-St. Lukes Medical Center in Chicago. With me is Dr. Roy Menninger.

We welcome the opportunity to appear on behalf of our organization to share our views on insurance coverage for those in need of treatment for nervous, mental or emotional disorders, both as now permitted under Federal law, and as may be developed in conjunction with a national health insurance plan.

As you may know, the objectives of the APA are: (a) to improve the treatment, rehabilitation and care of the mentally ill, the mentally retarded and the emotionally disturbed; (b) to promote research, professional education in psychiatry and allied fields; (c) to advance the standards of all psychiatric services and facilities; (d) to foster the cooperation of all who are concerned with the medical, psychological, social and legal aspects of mental health and illness; (e) to make psychiatric knowledge available to other practitioners of medicine, to scientists in other fields of knowledge, and to the public; and (f) to promote the best interest of patients and those actually or potentially making use of mental health services.

Naturally, we were gratified to learn that the Carter Administration when first in office, took an interest in and was concerned with the problems facing the mentally ill, and were equally gratified to note that the President's Commission on Mental Health, the group given the spearheading responsibility for this interest, stated in its preliminary report that "In our society, individuals must have the opportunity to have their suffering alleviated insofar as possible and \* \* \* no individual who needs assistance should feel ashamed or embarrassed to seek or receive help." Regrettably, as our current laws are drafted, as many private insurance plans are drawn, and as a national health insurance program may be developed, such is and may not in the future be the case.

Due to the stigma, fear and misrepresentation of mental illness—a tragedy perpetuated by authors such as Gross, Szasz and Ennis; the media such as ABC's televised "Madness and Medicine" and the conduct of everyday life itself—persons are reluctant to seek mental health services. Mentally ill persons are more likely than those with physical illnesses to delay or to reject early treatment. We are speaking of 20 to 32 million people who need mental health care. We are speaking of two million individuals who have been or would be diagnosed as schizophrenic; two million who suffer from profound depressive disorders; more than one million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. This is a large segment of our population to be left untreated, uncared for and therefore not part of the working, contributing population that weaves the economic and social fabric of our nation.

The stigma is heightened further because the discrimination has become institutionalized—written in the Medicare law, written in the restrictive language for treatment of mental illness contained in most of the national health insurance bills now pending before this Committee and restrictive measures contained in most private health insurance plans. All suggest that mental illness is grossly

different from physical illness—not treatable, not reversible and not equally reimbursable when treatment is provided.

The President's Commission on Mental Health pointed out in one of its recommendations the basic need regarding mental health insurance benefits, whether under Medicare or any other Federally developed health insurance program. It stated that "There should be minimal patient-borne cost sharing for emergency care. In all other instances, patient-borne cost sharing, through copayments and deductibles for evaluation, diagnosis and short-term therapy, *should be no greater than for a comparable course of physical illness.*" [Emphasis supplied.]

Such is not the case with Medicare, the program to which I now turn attention since it stands as a gross example of what a Federal health insurance program has done to assure mentally ill elderly Americans second class citizenship compared to that provided to them for other health care. I am speaking specifically of the restrictions imposed under both Parts A and B which arbitrarily reduce the benefit for mental health treatment below those benefits provided for the balance of medical care. Part A limits lifetime inpatient benefits to 190 days and Part B limits annual outpatient coverage for mental illness to \$250 per year (resulting from a \$500 ceiling and a fifty percent copayment)—including ancillary medical services.

The mentally ill elderly are stigmatized thrice—once by the fact of old age, once by the fact of mental illness, and once by the fact that treatment is too costly beyond the limited benefits of Medicare.

In 1971, the American Psychiatric Association Task Force on Aging, established to report on critical mental health issues identified by the 1971 White House Conference on Aging, pointed out that progress made during the previous two decades had been minimal. Among the reasons cited were the growth in number of the aging population, the recognition that their diversified needs may require diversified services, and that Medicare did not provide sufficient benefits to allow adequate reimbursement for the treatment of nervous, mental or emotional disorders. In Aging and Mental Health, Dr. Robert Butler, head of the National Institute on Aging, pointed out that "Medicare coverage for psychiatric disorders is unrealistically limited and was inserted as a kind of afterthought. The system obviously affords inadequate coverage."

It is a sad commentary to note that today, many of the same problems exist: the population of elderly persons continues to increase, and the number of those in need of mental health care continues to rise. In many ways, our recognition that diversified services are needed has languished, is unimplemented, and only now is the benefits package being reassessed. The General Accounting Office in its recommendations to the 95th Congress reported that mental health benefits under Medicare should be broadened. The Age Discrimination Study of the U.S. Commission on Civil Rights noted that the elderly are grossly underserved in comparison to other age groups within Federally supported Community Mental Health Centers. The President's Commission on Mental Health recognized the elderly as a target group which is "unerved, underserved, or inappropriately served" insofar as mental health care is concerned. The Report of the American Psychiatric Association's Task Force on the Chronic Mental Patient singled out Medicare as in need of amendment when it stated: "Chronic mental patients are entitled to full participation in the health care system. Medicare, Medicaid and future NHI, *should not single the chronically mentally ill out as a class or discriminate against them in any way.*" [Emphasis supplied.] Moreover, Senator Clifford Case and several of his colleagues recently introduced the Medicare Mental Illness Non-Discrimination Act (S. 3131), aimed at providing equal coverage under Medicare for the mentally ill elderly, and as many as four bills have been introduced in the House which have the same goal. The Senate bill is now pending before this Committee.

The benefits of expanded mental health coverage under Medicare are many. Too often the elderly are told, and many believe, that adverse psychological symptoms are natural aspects of growing old. Senility is a term loosely applied to thousands of older Americans, yet as the President's Commission on Mental Health noted, "as many as 20 to 30 percent of those so labeled have specific conditions that can be *diagnosed, treated and often reversed.*" [Emphasis supplied.] As such, Medicare costs would be ultimately reduced, and those individuals with reversible conditions would be able to become more productive, contributing and independent members of society.

Elimination of the discriminatory caps on Medicare as proposed by Senator Case and endorsed by the APA, would have other effects. As Senator Case pointed out when he introduced the Medicare Mental Illness Non-Discrimination Act:

"Elimination of the 50-50 copayment and enactment of the standard 80-20 copayment now used for physical health care will go a long way to ease the large cost burden imposed on those in need of mental health services.

"Elimination of the 190 day lifetime limit for inpatient psychiatric care and substituting the 'spell of illness' definition employed for the rest of medical care will result in greater attention being paid to appropriate placement in proper facilities for those in need of mental treatment as inpatients. Elimination of the annual \$250 ceiling on outpatient treatment for mental, nervous, or emotional disorders will result in greater utilization of outpatient services."

Moreover, it is essential to recognize that adequate, cost effective mental health services can have the effect of lowering the costs of other health care services by as much as fifty percent for the average patient. This is evidenced in study after study:

(1) In Texas, a longitudinal study (1973-77) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of the over-65 patients in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than \$1.1 million.

(2) Group Health Association of Washington indicated that patients treated by mental health providers reduced their non-psychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and X-ray services declined by 29.8 percent.

(3) Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of \$250 per year.

(4) Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from \$16.47 to \$7.06.

The cost of such legislation proposed by Senator Case—\$45 million—is fiscally responsible. The cost developed by the Social Security Administration, and borne out by the Report of the President's Commission on Mental Health, does not reflect the savings to be realized from anticipated lower hospitalization expenditures or the substitution for existing Part B expenditures. As noted in the Texas study, if the \$1.1 million savings were extrapolated to the entire Medicare population in need of mental health care, the effect could be a significant lowering of overall Medicare costs. Dr. Robert Butler, Director of the National Institute on Aging, pointed out in Aging and Mental Health that "There is also no proof that the deductible features of Medicare deter unnecessary use of health services. Instead, the exclusions may actually increase the government's bill by discouraging preventive and early rehabilitative care. \* \* \* Some old people get themselves checked into a hospital just to get a physical examination (basing it on some physical complaint) because this will not be paid for on an outpatient basis." The same situation is true for mental health coverage—other physical complaints form the basis for hospitalization or outpatient visits, thereby raising the cost of Medicare coverage and possibly masking the psychiatric illness with physical symptoms. All too often, inappropriate placement in skilled nursing homes and intermediate care facilities takes place since reimbursement is available for such "treatment." Such facilities generally lack the resources to treat the emotionally disturbed, thereby prolonging the illness and misutilizing resources.

It has been noted that as many as 30 percent of those described as "senile" actually have reversible psychiatric conditions, i.e., reversible treatable brain syndromes and depression which, if treated, would allow those individuals to become productive members of society and would save countless Medicare dollars. As such, the elimination of caps on mental health coverage under Medicare could prove a valuable fiscal yardstick against which to measure comparable parity coverage under national health insurance.

One of the mandates of the Older American Act of 1965, recently reauthorized by both the House and Senate and now awaiting Conference, is to assure inde-

pendence and dignity to this nation's elderly population. A major step in that direction would be taken by ending arbitrary discrimination against the mentally ill elderly who are doubly damned by the stigmas of age and mental illness.

Before concluding, it is important to point out that a major issue raised whenever mental health insurance coverage is considered is that of direct reimbursement to other mental health professionals and paraprofessionals who treat individuals with nervous, mental or emotional disorders. We cannot fully support direct reimbursement to other mental health professionals, unless their roles in providing supportive, not medical, services for such disorders is defined carefully or, alternatively, unless the Congress would authorize the provision of medically necessary or other supportive human services in treating nervous, mental or emotional disorders.

Of primary concern to the APA is maintenance of quality services to the public. This concern is shared by psychiatrists, other physicians and many leaders in the nonmedical health professions.

With regard to the treatment of nervous, mental or emotional disorders, it is critical to emphasize the unique role and function of the psychiatrist. While psychiatrists recognize that there are some similarities between psychotherapy and counseling, consoling and advising, there are also enormous differences. Psychotherapy and counseling are by no means interchangeable. The psychiatrist is not only trained to do psychotherapy, he is also trained to make differential diagnoses, to prescribe medication, and if need be, to hospitalize a patient for treatment. The kind of help that each professional offers is dependent upon the background, training, professional attitudes, knowledge, and special skills of the particular profession involved.

We believe that if direct reimbursement for other mental health care providers is to be considered, it is to be done so with clear specificity for the circumstances surrounding nervous, mental or emotional disorders which authorize differences for collaborative or individual independent responsibilities.

We are hopeful, Mr. Chairman, that you will give careful consideration to the serious and unmet needs of those requiring treatment for nervous, mental or emotional disorders, and that you will implement the recommendations of the President's Commission on Mental Health and those made almost ten years ago by the White House Conference on Aging concerning future directions in mental health care both now and during serious consideration of a national health insurance program for our entire nation.

Thank you.

**Senator MATSUNAGA.** The next witness is G. Kinsey Stewart, president, board of directors, and he will be accompanied by Dr. John Wolfe, executive director of the National Council of Community Mental Health Centers.

If Dr. Stewart and Dr. Wolfe, if you would take the witness chair.

**STATEMENT OF G. KINSEY STEWART, PH. D., PRESIDENT, BOARD  
OF DIRECTORS, AND JOHN WOLFE, PH. D., EXECUTIVE DIRECTOR,  
NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS**

**Dr. STEWART.** Mr. Chairman and members of the Senate Finance Subcommittee on Health, my name is Dr. G. Kinsey Stewart. I serve as president of the board of directors of the National Council of Community Mental Health Centers and am the executive director of the Gulf Coast Mental Health Center in Gulfport, Miss. With me is Dr. John C. Wolfe, executive director of our association.

The National Council of Community Mental Health Centers represents the organizations, boards and consumers of some 657 community mental health agencies nationwide and uniquely reflects this representation in our own board of consumers and professionals.

We are here to present to this committee our accumulated experience on medicare and medicaid over the past decade.

Since 1965 medicare coverage of mental health services has been unchanged. Originally modeled after the best private health insurance programs of the time and intended to avoid refinancing of State institutions, medicare in recent years has fallen far short of its goals.

By emphasizing hospital-based inpatient care, by limiting the use of ambulatory mental health service alternatives, and by restricting financing of outpatient care to physician care, medicare has been pennywise and pound-foolish. It concentrates over 80 percent of its mental health expenditures on inpatient hospitalization. Worse, it allows no freedom of choice to the elderly, who frequently are either inappropriately institutionalized or neglected and abandoned to welfare hotels.

This tendency to over-rely on institutional care is demonstrated in numerous ways through the limits and arrangements of the medicare program.

For example, it is no coincidence that HEW data on lengths of stay for mentally ill, elderly inpatients in State and county hospitals average over 53 days per episode, and that medicare pays 100 percent of the bill for elderly patients up to 60 days of hospitalization. Note: Inpatient lengths of stay in CMHC's average 14 days.

Medicaid coverage for mental health treatment is not much better. Although there are 53 different medicaid plans, most poor elderly patients who cannot afford the deductible or the copayment required by medicare, receive no help from the State's medicaid program. Data from HEW's social security office shows that less than 2 percent of all the elderly participating in medicare get help from medicaid, despite the high numbers of elderly who are below the poverty index in America today.

In Mississippi, my own center received only \$10,000 last year from medicare and medicaid combined, for serving over 480 patients—an average of only \$21 per patient. This deficiency of funding has been subsidized through over \$40,000 of our NIMH categorical grant. However, that grant is designed to be phased out in 2 years.

Termination of Federal categorical grant funds without medicare and medicaid reimbursement will mean that all current and future elderly persons needing care under our program will be either abandoned or referred to the State hospital. They could be treated in the community, where it is most meaningful and least disruptive of their lives.

Other defects in medicaid support for mental illness are:

First, discrimination against many adults in need of inpatient care by failing to cover those between the ages of 21 and 65.

Second, failure to fully reimburse for the cost of physician services.

Despite the lack of financing from medicare and medicaid for ambulatory mental health services, models of geriatric treatment programs which point to comprehensive treatment and continuity of care have successfully avoided high cost and restrictive institutionalization.

For example, in San Francisco, geriatric hospital commitments dropped from 500 per year to only three following startup of an

elderly screening and comprehensive community support program under which 44 percent of the elderly patients were maintained in their homes.

Similarly, in Harris County, Tex., the length of hospital stays was halved over a period of 4 years when outreach efforts targeted to aiding the elderly were successful.

A pilot study conducted in 1974 with Aetna Life & Casualty Co. demonstrated the cost-effectiveness of utilizing partial or day hospitalization services as a substitute for inpatient care. The study included 31 patients who otherwise would have been hospitalized. Aetna found that they saved over \$250,000 in 1 year by allowing treatment through this plan.

Partial hospitalization and screening and community support are among the services required from the complete system of care for the mentally and emotionally ill, furnished by community mental health centers. CMHC's emphasize ambulatory care and, since enactment of Public Law 94-63 in 1975, have been required to provide specialized services to the elderly.

Each CHMC serves a specifically defined geographic area termed "catchment area," and is responsible for a full range of services, early intervention and emergency services, an appropriate range of outpatient and other ambulatory care programs, partial hospitalization—day care and night care—halfway houses where appropriate, and 24-hour inpatient services.

CMHC's are also required by law to insure that all services are coordinated with the provision of other mental health, health and social services in the community. In planning CMHC services, agencies are required to review all existing service in the area, coordinate them to the maximum feasible extent into one program, fill in the gaps in services in the catchment area, and attempt to eliminate unnecessary duplication.

CMHC's have developed extensive outreach programs to insure that all individuals in the catchment area in need of services are both aware of their availability and encouraged to seek assistance.

The centers' preventive programs—consultation and education—include a wide range of indirect services which also help to establish an effective system of mental health care. Through CE, the centers reach into the schools, health agencies, law and correction agencies, welfare departments, et cetera, to educate personnel in these agencies about the services of the center and mental health issues in general, so that appropriate individuals are referred to the center for care.

Thus, a community mental health center, as defined by Federal law, is far more than simply an isolated Federal health program. The program is designed to make substantial impact on some of the most difficult and pervasive problems in health delivery, such as:

Accessibility—in terms of both geographical and socioeconomic factors.

Emphasis in preventive care and health education.

Emphasis on ambulatory care and other innovative alternatives to expensive 24-hour a day inpatient services where these services are not in the best interests of the patient.

Utilization of all mental health professionals and paraprofessionals in mental health teams.

Elimination of costly duplication of services to the extent feasible.

Yet, while CMHC's are working toward high priority goals of Federal health planners, they are caught in a financial bind due to the lack of coordination between the Federal categorical aid program, the CMHC Act, and third-party funding under medicaid and medicare.

Established on the basis of declining Federal categorical support, section 206(c)(1) of Public Law 94-64 (the CMHC Act of 1975) requires a community mental health center to:

Make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under Title XVIII of the Social Security Act, to medical assistance under a state plan approved under Title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program.

Ironically, in 1976, only 2.3 percent of all financing to community mental health centers derived from medicare. Estimates for 1977 and 1978 show no increase because most community mental health centers are excluded as providers from full participation in the medicare program. Although 15 percent of the CMHC's are operated by hospitals, 62 percent must rely on provider affiliation agreements with hospitals—which do not reimburse fully for services—and the remainder operate as freestanding clinics.

All three types of CMHC's operate essentially the same kind of service but are reimbursed differently because of status as providers. CMHC's not hospital based have extreme difficulty and, in some circumstances, are barred from, obtaining reimbursement for services which are fully reimbursed in hospital-based CMHC's.

The National Council of Community Mental Health Centers therefore urges this committee to support legislation introduced by Senators Hathaway and Stafford which amends medicare to:

One, establish provider status for federally sponsored community mental health centers and phase-in coverage of non-Federal mental health centers under standards established by HEW or the Joint Commission on Accreditation of Hospitals;

Two, establish coverage of partial hospitalization services;

Three, eliminate economic barriers to poor aged by allowing reimbursement of 10 CMHC outpatient visits annually.

These recommendations were among those supported in the report of the President's Commission on Mental Health, the task force on rural mental health, and the task force on mental health of the elderly, reported this year.

We wish to request that additional data (exhibit 2) on the cost and options for improving medicare coverage for mental health, as well as a copy of the bill introduced by Senators Hathaway and Stafford, S. 3425, be included in the record of these hearings.

This committee has the opportunity, I feel, to provide the citizens of this Nation with mental health care that they need, that they want, and that they deserve.

Thank you.

[The material referred to follows:]

## EXHIBIT 1

DAY HOSPITALIZATION AS A COST-EFFECTIVE ALTERNATIVE TO INPATIENT CARE:  
A PILOT STUDY

(By William Guillette, M.D., Brian Crowley, M.D., S. Alan Savitz, M.D., and F. Dee Goldberg, M.H.A.)\*

Two private day hospitals and an insurance company offering group health coverage to federal employees undertook a pilot study to determine if providing insurance coverage for day hospitalization on the same basis as for inpatient treatment was a feasible means of controlling the cost of psychiatric care. The study included 31 patients who otherwise would have been hospitalized; most had histories of severe psychiatric disorders and extensive treatment. Using the measure that the day hospital patients would have been in inpatient treatment for the same number of days, the authors estimate that the use of day treatment saved the insurer more than \$255,000. They recommend that day hospitalization be reimbursed on the same basis as inpatient care if a day hospital can meet stringent criteria ensuring that it provides active, appropriate treatment, and they present a list of such criteria.

Previous well-controlled studies have shown the effectiveness of day hospitalization as an alternative to inpatient care and, indeed, the superiority of the modality to inpatient care in several respects.<sup>1,2</sup> The main purpose of a study we conducted in the Washington, D.C., area was to determine whether day hospitalization was cost-effective from an insurance standpoint—that is, as a means of controlling the rapidly rising cost of inpatient care.

The escalating costs of hospitalization are well known. It has been estimated that \$1.7 billion could be saved each year by reducing by just one day the hospital stay of each mentally ill patient in the U.S.<sup>3</sup> Day hospitalization is considerably cheaper per day and, in most cases, requires shorter lengths of stay.<sup>4</sup>

Gunderson and Mosher point out that the costs of treating schizophrenia can be estimated to range between \$2.06 and \$4.01 billion a year. Of this amount, inpatient costs are \$2 to \$3.9 billion, and outpatient and aftercare costs, including day treatment, are \$60 to \$100 billion. They state: "Day hospitals, which are less expensive and seemingly equally efficacious for some schizophrenic patients, are now more available. Between 1967 and 1972, for example, all admissions to day care hospitals increased by 184 per cent. . . . It is ironic that the failure of most insurance companies to cover day hospital costs may actually increase their expenditures for inpatient services."<sup>5</sup>

Most group health policies equate day hospitalization with outpatient or office care; therefore, if day hospital treatment is provided for at all, it is almost always reimbursed at a lower rate than is inpatient care. Because of the limitations on out-of-hospital coverage, simple economics frequently dictate that the patient be hospitalized. We hope that the results of this study will help convince more third-party payers that for many patients day hospitalization is a cost-effective alternative to inpatient treatment.

\*Dr. Crowley formerly was medical director of the Potomac Foundation for Mental Health and Dr. Savitz was medical director of the Silver Spring Day Treatment Center; both are now in private practice in Washington, D.C. Mr. Goldberg formerly was administrator of the Silver Spring center and has been a staff member of the President's Commission on Mental Health. Dr. Guillette's address is Claims Department, Aetna Life and Casualty, 151 Farmington Avenue, Hartford, Connecticut 06156.

<sup>1</sup>M. I. Herz et al., "Day Versus Inpatient Hospitalization: A Controlled Study," *American Journal of Psychiatry*, vol. 127, April 1971, pp. 1371-1382.

<sup>2</sup>S. Washburn et al., "A Controlled Comparison of Psychiatric Day Treatment and Inpatient Hospitalization," *Journal of Consulting and Clinical Psychology*, vol. 44, August 1976, pp. 665-675.

<sup>3</sup>W. Furst, "Daycare: Comprehensive Management of the Mentally Ill Patient in the Community," *Sandoz Panorama*, December 1970, pp. 26-28.

<sup>4</sup>Herz et al., op. cit.

<sup>5</sup>J. G. Gunderson and L. R. Mosher, "The Cost of Schizophrenia," *American Journal of Psychiatry*, vol. 132, September 1975, pp. 901-906.

The study resulted from changes that Aetna Life and Casualty made in 1974 in mental health benefits for Aetna-insured federal employees in the Washington, D.C., area; Aetna decreased its coverage for outpatient treatment, which included day hospitalization, and thus incentives for using day care were severely decreased.

Two private day treatment centers, the Potomac Foundation for Mental Health in Bethesda, Maryland, and the Silver Spring (Md.) Day Treatment Center, began discussions with Aetna to try to have the benefits restored. Eventually a pilot project to determine if day hospitalization was cost-effective was designed. Aetna was to reimburse the participating day treatment centers on the same basis as for inpatient treatment, collect data, and review costs.

Detailed criteria for the facilities' participation in the study were established, to ensure that appropriate treatment would be provided. The criteria related to accreditation, psychiatric and other staffing, treatment planning, record-keeping and review, and emergency care, among other aspects of day hospital operation; at that time no generally accepted standards for day hospitals existed.

One of the primary requirements of the study design was that patients included in the study would otherwise have been hospitalized; additional rigid criteria for patient participation were established. To make sure that patients included in the sample met the criteria, the complete medical records of each patient were reviewed by Aetna's medical director for claims and also by an independent consultant, a physician associated with a private psychiatric hospital.

The study was begun in September 1975 and continued until June 1977. It was not a controlled study, partly because both centers were committed to the principle that inpatient hospitalization should be avoided and because patients were referred to the centers specifically for day hospitalization.

#### THE PATIENTS AND THE COSTS

A total of 31 patients—16 males and 15 females—were included in the study. Their ages ranged from 14 to 69, with an average of 30 years. Nine were married, one was divorced, 20 were single, and one was widowed. The majority of the patients had histories of severe psychiatric disorders and fairly extensive prior treatment.

Twenty-four of the patients were diagnosed as psychotic and seven neurotic. Eighteen of the 24 patients were schizophrenic, three others had a diagnosis of psychotic depression, two of involutional melancholia, and one of chronic psychosis. Of the neurotic patients, four had diagnoses of depressive neurosis, and there was one diagnosis each of anxiety neurosis, adjustment reaction, and alcoholism.

When the study ended, all but two of the patients had completed day treatment. The time spent in treatment ranged from three to 190 days, with an average of 53.4 days; the average length of treatment in calendar days was 88.5. The costs of treatment ranged from \$315 to \$17,829, with an average cost of \$5,019.71 per patient.

Eighteen of the 31 patients, or 58 percent, made significant improvement, as measured by the centers' treatment staffs. They once again became productive members of the community; that is, they returned to work, school, or family activities. Two patients required inpatient hospitalization; one improved and returned to day treatment, and the second appeared to need long-term inpatient care. The other 11 patients showed little or no improvement.

We knew of no valid method of determining the cost-effectiveness of partial hospitalization that would be acceptable to all sections of the health care field. We elected to base our calculations on the premise that if a patient had not been in a day hospital setting, he would have been in inpatient treatment for the same number of days. The measure is crude because obviously some patients might be hospitalized for a longer or shorter time, but we hope that eventually, with enough cases, the lengths of stay will average out and the calculations will yield fairly reliable statistics. We estimated the cost of inpatient care (including hospital and physician's charges) in the Washington, D.C., metropolitan area as \$150 a day, which we felt was a conservative figure.

On that basis, if the 31 patients had been hospitalized for the 1654 days they were in day hospital treatment, the cost would have been \$411,150. The cost of partial hospitalization was \$155,611; thus there was an estimated on-paper savings of \$255,839.

The amount actually saved can be debated indefinitely. However, if the savings were only \$50,000 and the care given was appropriate, it should be apparent that partial hospitalization is a cost-effective alternative for selected patients.

#### CRITERIA FOR REIMBURSEMENT

We recommend that day hospitalization no longer be equated with outpatient care in group health policies but reimbursed on the same basis as inpatient care. However, we make that recommendation with the proviso that, to be eligible for such reimbursement, a day hospital should meet stringent criteria ensuring that it provides appropriate, intensive, high-quality treatment rather than primarily custodial care or training or recreational activities. The criteria established for facilities' participation in the Aetna study would appear to be suitable guidelines:

The program must be accredited by the Joint Commission on Accreditation of Hospitals' Council for Psychiatric Facilities. It may be accredited either as a separate facility or as a service within a facility accredited by JCAH.

The program must be licensed under any existing licensing requirements in that jurisdiction. Where required, the facility must be approved by the applicable health agency and the state certificate-of-need agency.

The program must develop and maintain a long-range development plan approved by the facility's board of directors.

There must be explicit and detailed statements of objectives that include a description of who shall be treated, for what conditions, and by what methods.

The program must have a director who is a board-eligible psychiatrist and who has enough day-to-day clinical and administrative responsibility for the program to assure that there is always adequate psychiatric manpower to meet the program's objectives. The program must be staffed by at least three licensed and board-eligible psychiatrists who are directly involved in the program by providing services to patients, training, and staff supervision. Documentation that a psychiatrist is present at all times during the treatment day must be available.

A registered psychiatric nurse with at least two years' experience in psychiatric programs must be present at all times during the treatment day, as well as other appropriate professionals such as a licensed clinical psychologist, a qualified psychiatric social worker, or both. There must be sufficient professional staff to maintain the objectives of an intensive treatment program.

The program must operate a full day treatment program at least five days a week.

A staff psychiatrist must provide weekly consultation, which includes clinical assessments of patients, to the treatment staff and must conduct appropriate psychotherapy with each patient. Adequately supervised treatment by a psychiatric resident will be acceptable in lieu of direct treatment by a staff psychiatrist.

The program must have individualized treatment plans that include regular input from the psychiatrist. Such plans must include a formal mechanism for discharge planning that is designed to discharge patients promptly to other, more appropriate levels of care. The discharge planning mechanism must be documented, with the documentation available on request.

The program must provide emergency psychiatric care, including overnight care if necessary, and must have a demonstrable capability to respond promptly to crises and emergencies 24 hours a day 365 days a year. Independent, free-standing facilities must have a written agreement with a hospital for the provision of such care.

The program must have the necessary equipment and staff to provide first aid in medical emergencies.

The program must maintain current and complete medical records for each patient, and the records must be available for review, on request, for claims adjudication and for utilization review. Each medical record must contain an admitting notation and diagnosis by a psychiatrist; a complete psychiatric history; a report of a current physical examination, including a medical history and results of necessary laboratory tests; a current and complete treatment plan, including prognosis; and, for discharged patients, a discharge summary.

The program must have a comprehensive written plan for external utilization review and detailed records of utilization review meetings. Utilization review must be conducted at least twice a month by a visiting board-eligible psychiatrist; the psychiatrist must not be beneficially related in any way either to the program or to the facility in which the program is located.

The physical facility and space provided by the program must be adequate for the provision of intensive psychiatric treatment.

Facilities functioning primarily as schools or as training, custodial, or recreational institutions will not be considered day hospital programs for purposes of reimbursement. Schooling, therapeutic or otherwise, is also excluded, as are programs in which schooling is a major modality.

Adequate financial and other records or information must be made available to the insurer so that adjustments may be made for schooling and other non-medical and nonreimbursable services.

In America psychiatric treatment has been dominated by the use of inpatient hospitalization. In recent years many long-term custodial patients have been discharged to the community, to situations as bad as or worse than they faced as an inpatient. We believe that even more emphasis must be put on alternative forms of psychiatric treatment. Day hospitalization appears to be among the most promising currently available modalities, both clinically and economically.

But in spite of its obvious clinical and economic advantages, day hospitalization has seldom been successful in the private sector. Since the pilot project was completed, the two facilities involved in the study have closed. Their closing was a loss to their communities and is indicative of the difficulties day hospitalization faces in competing with inpatient treatment. We hope that this study will encourage third-party payers to eliminate the differentials in coverage of the two modalities and thus to give support to a highly beneficial modality.

#### EXHIBIT 2

##### ISSUE PAPER: MEDICARE MENTAL HEALTH LEGISLATIVE IMPROVEMENTS

(By Jerrold J. Hercenberg)

Medicare coverage of mental health services has been unchanged since 1965. The lack of adjustment of Medicare to federal and state deinstitutionalization efforts and strategies to promote ambulatory mental health services (particularly through CMHCs) has contributed to the abandoning of many elderly and disabled Americans in need of mental health care.

Originally designed to concentrate federal funds for active treatment, the current Medicare program attempts to avoid refinancing of state institutions, non-medical services, and over-utilization of "faith healer services," by placing limits on the lifetime use of inpatient services and limiting outpatient coverage to a maximum of \$250 annually while requiring a 50 percent copayment, a financial obstacle to care for many Medicare eligibles. Thus, Medicare has been penny-wise and pound-foolish, concentrating over 80 percent of its mental health care investment in acute care inpatient hospitalizations.

As a result, this system of financing has created numerous disincentives which:

- (1) Make it easier to institutionalize patients than to provide ambulatory care;
- (2) Establish no effective controls over the proper use of services and treatment;
- (3) Reimburse health agencies and providers more (in some instances) than mental health specialties for mental health services and treatment; and
- (4) Promote unnecessary utilization and irrelevant treatment of patients through health care providers (particularly ICF's, nursing homes, and other inpatient facilities) when mental health services are needed.

Pending are three proposals to adjust the inadequacies of mental health coverage under Medicare:

*Option A.*—Increase the federal copayment from the current effective 50 percent to a straight 80 percent of up to \$500 (similar to the rate for physical health).

*Option B.*—Increase the reimbursement limit from the current effective ceiling of \$250 to an effective limit of \$750

*Option C.*—Establish a new class of Medicare provider—CMHC's—to be fully reimbursed for up to 10 outpatient visits and reimbursed for partial hospitalization services, with demonstration programs for future development of mental health service coverage

While both Options A and B appear on the surface to alleviate discriminatory patterns in Medicare, they both have significant drawbacks for a low cost Medicare improvements bill:

(1) High cost to Medicare (together they may cost as much as \$180 million extra annually).

(2) Limited benefit to consumers—the 80/20 copayment would ease financial burdens but would not necessarily improve current utilization or availability of services; the \$750 reimbursement limit change would only benefit those patients able to afford more services, offering no relief to poor or near poor Medicare recipients who live in states with non-mental health Medicaid programs or are ineligible to participate.

(3) More incentive for private practitioners to abandon organized care settings.

(4) No data or control procedures to assure appropriate utilization of outpatient mental health services.

(5) Failure to address current and pending reductions in existing community mental health center services from centers that have completed basic federal support and are unable to maintain outpatient services due to inadequate third party financing.

In contrast, Option C offers low cost and judicious improvements to Medicare:

(1) Equitable reimbursement for identical services for all mental health providers at minimum cost to Medicare and maximum benefit to consumers.

Because current provider status criteria were developed for physical health care settings, many CMHC's do not qualify as full providers. Consequently, reimbursement rates for the same mental health services vary among CMHC's (depending on provider affiliation) and are sometimes even higher for general health care providers (lacking mental health expertise) than for CMHC's.

CMHC's were specifically created by Congress to provide specialized mental health services at low cost and rely increasingly upon third party payments to finance such services. Yet many CMHC's face financial distress and services cutbacks in fiscal year 1979 when 137 additional CMHC's will terminate federal categorical support. Establishment of CMHC's as a discrete provider class under Option C would avoid dismantling many existing services by increasing the percentage of CMHC budget from Medicare (from the low level of 2.3 percent of CMHC revenues nationwide in 1976). Thus, equitable reimbursement depending upon the type of services offered and based upon criteria for mental health services would:

Improve elderly utilization by expanding service availability;

Reduce inappropriate high cost treatment;

Increase incentives for physicians to practice in CMHC's; and

Alleviate financial distress of "graduate" CMHC's.

Further, the cost of implementing a new CMHC provider class, which allows full reimbursement for up to 10 outpatient visits and allows partial hospitalization as an alternative to inpatient services, would not exceed \$13.9 million in the first full year of operation.

(2) Data and federal controls for improved accountability and cost efficiency of mental health services.

Alarmingly, the Health Care Financing Administration maintains no up-to-date or detailed records of annual mental health inpatient or outpatient expenditures or data (from service utilization patterns, provider data, client population status data, or costs) to forecast future demand and costs for services.

A refined data base and well managed planning of future mental health services, developed through controlled growth and demonstrations, are essential given the HEW projection that mental health coverage in Medicare is expected to rise from the current level of \$250 million annually to over \$500 million by 1985.

ADAMHA and HCFA would be required to define reimbursable services, utilization review requirements, and cost controls for CMHC's which standards would then be tested under a three-year demonstration program. This demonstration program would produce data necessary to determine major statutory changes for mental health Medicare improvements based on:

Outpatient reimbursement incentives;

Costs and offsets to Medicare physical and mental health reimbursement;

Quality of services and comparative costs through well developed management techniques; and

Effects of increased mental health service alternatives on deinstitutionalization.

*Computation of maximum medicare liability for outpatient mental health coverage (options A and B)*

[In millions of dollars based on 150,000 outpatients in fiscal year 1977]

Method 1:

Proposed 80/20 copayment, \$500 limit (\$400 reimbursement)	\$60.0
Current 50/50 copayment, \$500 limit (\$250 reimbursement)	37.5
Increase for implementation of 80/20 copayment	22.5
Proposed \$750 maximum reimbursement	112.5
Current \$250 maximum reimbursement	37.5
Increase for implementation of \$750 ceiling	75.0

The actual increase for implementation of both changes cannot be determined precisely because the conjugal effect would create additional demand. The minimum increase would be \$75 million (cost for implementation of \$750 maximum reimbursement).

Method 2:

Costs under current law :	
Total 1976 CMHC outpatient expenses (estimated)	\$4.4
Total 1976 medicare outpatient expenses (estimated)	37.5
Costs under proposed changes :	
1. Overall shift in Coinsurance to 80 percent of \$500 maximum :	
(a) For CMHC's (Federal)	\$6.9
(b) Total medicare (includes CMHC's)	58.8
2. Increase in total reimbursement for outpatient coverage (up to \$750 maximum) :	
(a) For CMHC's (Federal)	\$15.8
(b) Total medicare (includes CMHC's)	134.5

Assumptions for both methods

1. Maximum reimbursement for all patients annually from all current providers.
2. No offset to costs (e.g., hospitalization) under title XVIII.
3. Zero percent inflation between fiscal year 1977 and time period when proposal takes effect.
4. No additional demand for mental health services from current eligible non-users.

**LOW COST CMHC MEDICARE IMPROVEMENT LEGISLATIVE PROPOSAL**

*Stage 1: fiscal year 1979*

- (1) Establish provider status for community mental health centers which :
  - (a) Meet requirements of Public Law 94-63;
  - (b) Have all mental health care coordinated by a mental health professional;
  - (c) Meet all requirement for local licensing;
  - (d) Meet HEW requirements for record keeping and accounting;
  - (e) Meet staffing requirements;
  - (f) Meet stringent requirements for quality assurance and utilization specified in the Act.
- (2) Establish a new Medicare category of mental health services labeled "partial hospitalization services in community mental health centers," available as a substitute for inpatient services on the basis of 4 visits per inpatient day, up to 60 visits per year. [NOTE.—Currently, Medicare spends more than 80 percent of its mental health coverage on inpatient care. The substitute service offers an ambulatory alternative which may reduce cost from \$200 per day inpatient to less than \$60 per visit for full day treatment and rehabilitation.]
- (3) Establish a new Medicare category of mental health services labeled "outpatient services in a community mental health center," allowing a mental health center to continue less intensive treatment for patients up to 10 visits annually. [NOTE.—Current limitations in the law inhibit utilization of services under Part B of Medicare, due to the high copayment rate.]

*Stage 2: Fiscal year 1980-81*

(4) Establish provider status for commodity mental health centers which meet national HEW standards and certification (in lieu of requirements under Public Law 94-63) and which conform to requirements listed in 1 (b)-(f) above.

National standards should be developed jointly between the Health Care Financing Administration and the Alcohol, Drug Abuse and Mental Health Administration on the basis of:

- (a) Core standards for all community mental health services programs;
- (b) Definitions of services, utilization and quality assurance review requirements, and cost containment of services.

Community mental health center standards developed by the Joint Commission on Accreditation of Hospitals could be substituted for HCFA certification beginning in fiscal year 1980.

*Maximum cost estimates for mental health medicare improvements for Federal CMHC's*

[In millions of dollars for 1 full year of operations]

Total 1976 medicare costs in CMHC's-----	\$21.8
Estimated total 1976 medicare outpatient costs in CMHC's-----	4.4
<b>1. Low-cost CMHC medicare improvements (option C) :</b>	
(a) Federal CMHC provider status allows all CMCH's meeting requirements of Public Law 94-63 to have billing status under title XVIII (assuming no change in outpatient limits): Outpatient increase-----	7.1
Total (a)-----	\$7.1
(b) Covers up to 10 outpatient visits in Federal CMHC's as part of new provider category-----	6.8
Total 1 (a) + (b)-----	13.9
<b>2. Change copayment rate (option A) :</b>	
Allows 80 percent of \$500 maximum reimbursement for outpatient services -----	6.9
Estimate assumes provider status [1(a) above]-----	8.71
Total 2 (1(a) plus 2)-----	15.61
<b>3. Change outpatient limit (option B) :</b>	
Allows reimbursement for outpatient services up to \$750 maximum -----	15.8
Estimate assumes 80/20 copayment (2 above)-----	15.61
Total 3 (2 plus 3)-----	31.41

*Assumptions*

1. Maximum reimbursement for all patients treated under title XVIII annually from all current providers.
2. Change in provider status will :
  - (a) Affect only free-standing CMHC's for Medicare inpatient;
  - (b) Result in shift in reimbursement to cost basis for outpatient;
  - (c) Result in substitution of partial hospitalization for some inpatient services reflecting higher outpatient of proposed changes.
3. Zero inflation between 1977 and implementation of proposed changes.
4. No increase in demand for mental health services under title XVIII.
5. No offset to overall costs under title XVIII.

NOTE.—See CMHC data sheet for explanation of cost estimates.

**EXPLANATION OF LOW COST CMHC MEDICARE IMPROVEMENTS—CMHC DATA SHEET**

[1976 figures]

Type of CMHC	CMHC's	Providers	Average reimbursement	Title XVIII source
General hospital-----	103	103	\$107,000	A and B.
State mental hospital-----	15	15	60,000	A and B.
Private psychiatric hospital-----	11	11	132,000	A and B.
Free standing-----	68	42	40,000	A and B.
Hospital affiliated-----	351	0	19,000	B only.
<b>Total-----</b>	<b>548</b>	<b>171</b>	<b>40,000</b>	

Creation of a new provider category under Title XVIII would primarily benefit non-general hospital-based CMHC's (which currently do not hold full provider status).

If provider status is granted under current Medicare law (\$250 outpatient limit, 50 percent copayment), average reimbursements to centers theoretically could rise to the general hospital-based CMHC level (\$107,000). However, approximately 80 percent of current Medicare reimbursements for general hospital-based CMHC's is for inpatient costs. Inpatient services in current non-status CMHC providers will not be utilized to the same extent as in general hospital-based CMHC's. Thus, for most CMHC's obtaining comparable status to general hospital-based centers, no additional inpatient reimbursements may be anticipated.

Provider status would equalize reimbursement for outpatient services on an actual cost basis for all types of CMHC's. The additional outpatient cost for non-general hospital-based CMHC's is based upon the difference between the current total of outpatient reimbursements and the projected total of outpatient reimbursements after equalization. Simply, this amounts to 20 percent of \$35.7 million, or \$7.1 million.

Further, in establishing a CMHC provider class, it is desirable to encourage outpatient services within controlled limits. Unlike proposals to change the copayment feature or the fixed dollar limit, a proposal to cover 10 outpatient visits in CMHC's (without copayment) would:

- (a) Increase services to needy elderly;
- (b) Reduce the burden for payment;
- (c) Be subject to closer utilization review and controls; and
- (d) Provide data from which Congress could further determine the desirability of outpatient mental health care.

Finally, this proposal would not break the bank. The estimated cost of providing 10 outpatient visits to the current CMHC Medicare population is \$6.8 million annually (20,000 outpatients times 10 visits times \$40/visit less \$60 deductible).

Senator MATSUNAGA. Thank you very much.

Dr. Stewart or Dr. Wolfe, whoever prefers to answer, granted that there are many good mental health centers, are there many poor ones as well? If so, exactly how should they be sorted out?

Mr. STEWART. How should they what?

Senator MATSUNAGA. There are good mental health centers, but presumably there are also poor ones, which do not perform as well as they ought to. How should these centers be sorted out? In what way could we distinguish the good centers from the poor centers so that we may protect the public, in as much as the Federal Government is helping to finance these centers?

Mr. STEWART. My anxiety over my original staffing grant running out at the end of this month caused me to hear you were poor in terms of a money situation, but I hear what you are saying.

John?

Mr. WOLFE. I think any of the centers federally funded are certainly scrutinized in varying degrees by the agency providing the funds; namely, the National Institute of Mental Health. NIMH has had its own problems and difficulties in terms of not having enough staff and the reorganization that took place a few years ago at the regional level.

Indeed, centralization, which I think has contributed to the fact that the centers many times have not received the technical assistance of monitoring necessary. I do not think that speaks to any center intentionally trying to provide poor services, but they have need of assistance, but have not been able to receive it from the funding agencies itself, namely the Federal Government.

Senator MATSUNAGA. Is it true that many mental health centers are understaffed and perhaps, as a consequence, or due to other causes, are costly and improperly managed?

**Mr. WOLFE.** I would not draw that conclusion. Many mental health centers have a difficulty in the charge given to them by the Government in the sense that they are to plan and provide services to all people within their catchment area. The funds and the expectations have not matched the reality in terms of the moneys being available.

This, in itself, has caused many problems in providing services that the centers want to provide. I think the areas you were addressing today in terms of medicare speaks to that. It was the intent back in 1963 that the centers would, indeed, be picked up by other forms of reimbursement and that has not followed either through legislation or other third party payments.

This has resulted in some centers having fiscal difficulties which, in turn, reflect in the kind of services they can provide.

**Senator MATSUNAGA.** There is some allegation that specific and scientific evidence is lacking to demonstrate the efficacy of the treatment provided in mental health centers. Is there any truth to his claim? Can you point to any evidence to the contrary?

**Mr. WOLFE.** Yes; I think the testimony we heard from psychologists and psychiatrists today would speak to that. Indeed, the staffs at the mental health centers are staffed by psychiatrists, psychologists, social workers and nurses.

The issue I hear in the question is whether or not psychotherapy and treatment by the disciplines can be effective or not. That is the issue at the mental health centers—the issue that psychotherapy is indeed something helpful. I believe it can be, and I think there is evidence to that effect.

**Senator MATSUNAGA.** Could you provide such evidence for the record?

**Mr. WOLFE.** Certainly.

**Senator MATSUNAGA.** I would appreciate that.

[The following was subsequently supplied for the record:]

#### PROGRAM EVALUATION SUMMARY : NIMH COMMUNITY PROGRAMS

(By J. Richard Woy, Ph. D.)

##### I. BACKGROUND AND INTRODUCTION

The purpose of the Community Mental Health Centers (CMHC) program is to make comprehensive community-based mental health care available to every resident of this country. Begun in 1963, this program has sought its goal by providing project grants to initiate CMHC's. Grants to build or renovate facilities and grants to hire staff and pay other expenses have both been provided. Each Federally funded CMHC must provide a wide range of mental health services including a variety of inpatient, ambulatory, and indirect services, and each Center is responsible for the mental health needs of a specific geographical area. As the Federal "seed money" in each CMHC declines and then terminates over a period of eight years, each Center is expected to find other sources of revenue to insure its continued operation. The Federal program is administered by the NIMH through the 10 DHEW Regional Offices across the country. There are approximately 600 operating CMHC's for the approximately 1,500 possible catchment areas in the United States, and the current fiscal year 1978 appropriation for CMHC's is approximately \$250 million.

Since 1969, the NIMH has conducted over 50 evaluation studies of the CMHC program at a cost of approximately \$5 million. In addition, the Division of Biometry and Epidemiology of NIMH regularly collects and analyzes extensive and detailed information about CMHC's, and a number of other studies and analyses of the CMHC program have been conducted by non-government orga-

nizations. While the overall cost of these many studies is only a tiny fraction of the Federal investment in the program, the CMHC program has been studied and analyzed much more intensively than any other component of the nation's mental health system and perhaps more than any other Federal program of comparable size and importance. As a result, space limitations preclude inclusion of all of the potentially relevant evaluation findings in this brief summary.

## II. FEDERAL POLICY RELEVANT KNOWLEDGE

### *A. Services effectiveness*

The effectiveness of the CMHC program may be viewed from four different perspectives: (1) measures of effort, (2) process achievement, (3) client outcome, and (4) community impact. The NIMH's approach to evaluation of the CMHC program has been to remain within the boundaries of current evaluation research technology and to examine issues relevant to improvement and refinement of the program.

In terms of measures of effort, the CMHC program clearly has been a success. Since 1963 nearly 600 CMHC's have been initiated, making CMHC's services available to over 40 percent of the residents of the United States. The range and quantity of mental health services utilized by the American public has increased rapidly during that period, and a significant portion of that increase can be attributed to the CMHC program.[1] In 1976, almost 1.9 million people were under care in Federally funded CMHC's, and the average CMHC reported a caseload of 3,426 persons of which 1,854 were new additions during that year. During the past eight years, the caseload in the average Center has more than doubled, and the unduplicated count of new additions each year has increased some 70 percent. In addition, a ten-year longitudinal study of matched pairs of counties, one of each pair with a CMHC and one without, found that areas with CMHC's tend to develop not only more mental health services over the course of time, but also more health and human services programs than do areas without CMHC's.[2] The program has not yet achieved the goal of covering the country with CMHC's, but there has been significant progress.

The CMHC program has a number of process objectives, ways that services should be provided if CMHC's are to truly meet the mental health needs of their communities; and a number of evaluation studies have examined the extent to which CMHC's are accomplishing these process objectives.[1] Active citizen participation in CMHC's operations has been a goal from the beginning, but, studies of citizen involvement in CMHC's revealed weaknesses in this area.[3, 15, 16] CMHC's are required to provide for the mental health needs of all the residents of their catchment areas, and yet studies of Centers' services to the elderly,[4] children,[5] and patients discharged from State mental institutions[6] have revealed deficiencies in services to these groups. A key concept in the CMHC program is that of accessibility; a study of the accessibility of CMHC's found strengths and weaknesses in this area and recommended increased involvement with other caregivers, more publicity, and use of satellite clinics.[7] These studies have played a part in discussion of the CMHC legislation, and the Community Mental Health Center Amendments of 1975 (Title III of Public Law 94-63) revised the earlier legislation in ways designed to solve the problems identified in these studies. Results of a recently completed study, however, indicate that weaknesses in Centers' services to the elderly and to patients discharged from State mental institutions still remain.[8] It should be noted that none of the above studies of Centers' achievement of process objectives compared CMHC's to other medical health programs, but rather measured Centers' performance against the CMHC Act's ambitious goals; and so the studies' results do not indicate that the CMHC program is either superior or inferior to other mental health programs in these areas.

As indicated above, the effectiveness of the CMHC program can also be viewed from the perspectives of client outcome and community impact, and, of course, ultimately these are the most important perspectives from which to assess the program. Unfortunately, the effects of CMHC's and of other components of the nation's mental health system, including the private sector, upon the emotional well-being of their clients and their communities are not known at this time. Questions about the effectiveness of basic mental health treatment tools such as psychotherapy remain unresolved, and scientific assessment of the effects of complex organizations upon the mental health of their clients and their host

communities is still in its infancy. The NIMH has supported a number of projects to develop better research strategies in this area and to disseminate the best current methods.[17, 18, 19, 20]

#### *B. Costs and efficiency*

The most important studies in this area have been those examining the "seed money" concept. Because Federal funding of CMHC's is done on a declining formula basis, individual CMHC's must obtain alternate sources of funds prior to termination of the Federal grant if they are to survive. Whether or not CMHC's were making appropriate preparations and would in fact succeed in making an adequate transition to other sources of revenue has been an object of study and concern for some years[9, 10, 11] because the survival and growth of the community mental health system in this country depends upon it. A recently completed study[12] examined a cohort of CMHC's which had completed their eight years of Federal grants and found that while the Centers remained fiscally viable, they quickly began to compromise the CMHC ideology in response to the constraints of their new funding sources. In particular, the investigators found increasing inpatient care and decreasing ambulatory and indirect services in the cohort of Centers. The study's final report recommended additional "maintenance" funds for CMHC's after the end of the eight years of Federal grants, more funds for Consultation and Education grants, and inclusion of CMHC's as providers under any future national health insurance program.

A second recently completed study examined differences between those Centers that have terminated their Federal CMHC grants after eight years and remained self-sufficient and those Centers that have completed their eight years of Federal grants but have sought and been awarded additional grant funds under the Community Mental Health Center Amendments of 1975.[13] The findings indicate the continued funding group have not been very successful in obtaining alternate sources of funds and need the additional Federal funds to survive. The other group of Centers has been quite successful in obtaining alternate sources of funds, particularly third party reimbursements, but appears to be changing its programs and mix of services away from the CMHC model. These Centers appear to be emphasizing inpatient services, which are more easily and generously reimbursed than ambulatory services under Medicaid and many private insurance plans. This study indicates the serious need for a stable ongoing source of funding for all of the services rendered by CMHC's if the whole range of community mental health services are to remain available.

#### *C. Management*

The management of the CMHC program has at least two layers and in some cases several layers. The NIMH and the 10 DHEW Regional Offices manage the program from the national level, and there is an extensive system for development, review and approval of new CMHC grant applications, a system to develop and disseminate regulations and guidelines for the program, a program to review and approve annual CMHC project updates, a program to provide technical assistance and training in management to CMHC's, and a program of site visits by Regional Office staff to assure implementation of the CMHC law and regulations in the individual CMHC's. The second layer of management, of course, is the management of the individual CMHC's themselves. Finally, because State and county governments contribute heavily to the support of CMHC's and ultimately assume much of the responsibility for ongoing support of the CMHC's after the end of Federal grant funding, staff of State governments often actively participate in the monitoring and oversight of CMHC's in their States.

A study in progress is examining the Federal and State government's management and oversight of the CMHC program. [14] Results will be available in the fall of 1978. Concerning the management of the individual CMHC's themselves, a number of studies have found deficiencies in the fiscal management of CMHC's, particularly Centers' cost accounting systems and mechanisms to recover fees and third party reimbursements. [9, 10, 11] Studies discussed above under the topic "process objectives" can be viewed as studies of the effectiveness of CMHC's internal management, and a number of studies have noted the need for improvements in the internal management of CMHC's. [9, 10, 11, 21] Perhaps more than any other Federal social program, NIMH has encouraged CMHC's to evaluate their own services and programs, and the CMHC Amendments of 1975

now make self-evaluation by CMHC's mandatory. An evaluation of this self-evaluation activity in CMHC's is now in progress. [22]

#### D. Reform initiatives

Currently, there are a number of proposals for modification of the CMHC program, including several legislative proposals and the recommendations of the President's Commission on Mental Health. Space does not permit discussion of the relevance of evaluation research findings to each proposal; however, the findings reported above clearly add to the weight of evidence for or against various of the proposed changes in the program. In addition, other evidence not reported here is relevant.

### III. ALTERNATIVE INTERPRETATIONS AND PERSPECTIVES

During preparation of this summary, no significantly different view as to interpretation of the evidence was proposed.

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**REPORT OF THE TASK PANEL ON COMMUNITY MENTAL HEALTH CENTERS ASSESSMENT**

**TASK PANEL: COMMUNITY MENTAL HEALTH CENTERS ASSESSMENT**

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**INTRODUCTION**

The community mental health center program is at a crossroads. Developed on the premise that a declining Federal contribution would produce stable financing after a period of time, it is now "graduating" centers into a world of fiscal constraint and uncertain expectations. To merely discuss establishing further centers would seem rather self-defeating, so long as the premise of the community mental health center (CMHC) program makes possible the disappearance or diminution of proven programs 8 years after they are established. And yet there is a clear need for additional community mental health centers and services.

Substantively, there is a crossfire of criticism. Observers point to the relatively limited role the centers have played in key areas like prevention, services to populations at special risk, and services to the previously institutionalized. Furthermore, it is contended that this proves, variously, the overpromising of the program; the impossibility of performing these tasks; the fundamental racial, ethnic, and income cleavages in American society; the lack of commitment of the

mental health professions; or the political reality of the appropriations process at all levels of government.

We take a rather different view. We strongly support community mental health services and community participation in the planning and oversight of such services. We believe a significant number of the community mental health centers have made substantial contributions to the development of needed community mental health services. And we think absurd priorities in any field can be altered if adequate efforts are made over a period of time.

In the constellation of Federal programs, the CMHC's have been, in fact, a distinctly small item, currently costing less than a quarter of a billion dollars a year for their categorical appropriation. The program has received a total of approximately \$1.5 billion in categorical Federal funding during the entire 14 years it has been in existence.

Yet this relatively small funding has brought 590 operational community mental health centers to areas around the country, with another 85 funded but not yet operational. With all the criticism that has been leveled about the failure of the centers to attract other resources, every dollar put in by the CMHC program itself leverages three other dollars of support. The bulk of this additional support is from non-Federal sources. In community after community around America, the CMHC program has created important, useful mental health services that would not be in existence if the program had not produced them.

At the same time, there are serious problems that remain throughout the entire country in regard to delivering mental health services. Overall, neither the quantity nor quality of available services is sufficient. Some areas have virtually no community mental health services; others have gaping deficiencies for certain populations. Even where there are CMHC's, there is often a distressing lack of service for previously institutionalized patients returning to the community. In addition, not enough is being done to prevent initial institutionalization. The populations especially at risk, as recognized in the 1975 CMHC legislation—children and youth, the elderly, and substance abusers—are frequently underserved. While the CMHC program has made generally successful efforts from the outset to target services toward minorities and the poor, there are still gaps in these areas.

A special problem is the connection of some centers to the communities of which they are supposed to be an integral part. The nature of this problem in any given community, in those instances where it is a problem, will depend on the form of the CMHC in that community. If it is run by a State or local government authority that has historically tended to bureaucracy and lack of capacity to reach out to people who need to know there is a way they can get help, the problem of connection is of one sort. If, at the other extreme, the CMHC is a freestanding program governed by people from the community, the problem may be the exact opposite: failure to be part of a functioning network of human services in the relevant geographical area.

This, in turn, highlights two key introductory points: the tremendous diversity of the program that is encompassed in the community mental health center concept in terms of auspices, governance, location, size, pattern of service, and all the rest; and the fact that many of the program dilemmas are hardly the fault of individual centers. Over the past years there has been a failure of Federal oversight, technical assistance, evaluation, and leadership that is at the heart of the current matter. It is important to note that over these same years previous administrations had sought to end the program, arguing that a successful demonstration project no longer needed to be demonstrated. In the face of this erosion of support (manifested most strikingly by the administration's impoundment of congressionally authorized funds) and diminishing resources for program support, there has been an increasing need for such services and leadership. In many ways, to criticize the centers themselves for many (but not all) of their failings is to "blame the victim."

To the same end we would stress as strongly as we possibly can that there will never be any real hope of adequate community mental health services so long as over half the American mental health dollar is spent on State institutions and mental-health-related nursing home care. If the Commission is unable to print a clear path toward Federal policy that will alter the current balance of expenditures, we doubt the efficacy of anything that it might recommend regarding community mental health centers and services.

Our deliberations elicited a cascade of observations about the changes in the context of the CMHC program over the past 14 years: changes in expectations

about what the program can accomplish; changes in the financial and economic environment; changes in the professions and the public's attitude toward them; changes in the "medical model" of treatment and associated changes in the manpower mix; the development of consumerism, advocacy, and legal rights in health and mental health care; and many others.

If there is one change we could point to above all, however, it is this: when the CMHC program was instituted, the centers were the visible symbol of mental health services in the community. Now there are many new services and programs which are often unassociated with CMHC's.

On February 5, 1963, President John F. Kennedy sent to Congress the first Presidential "Message on Mental Illness and Mental Retardation." In it, he proposed a "national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill."

President Kennedy's program was, in a sense, the culmination of a century of struggle to gain Federal support for mental health services. President Franklin Pierce had, in 1854, vetoed legislation which would have made Federal land grants available to facilitate the development of public mental hospitals, stating that he could find no constitutional authority for the Federal Government to be "the great almoner of public charity throughout the United States."

The Depression of the 1930's, which created a new Federal role as initiator and supporter of national social welfare programs, eroded that constitutional position. After World War II, accounts gathered from among the three thousand conscientious objectors who had served in State mental hospitals helped reveal to the public the abysmal conditions among the neglected civilian mentally ill. The returning military clinicians also helped stimulate a new wave of interest in treatment for mental illness. This led first to the establishment of the National Institute of Mental Health in 1946, and then to the creation in 1955 of the Joint Commission on Mental Health and Mental Illness, the report of which was a major underpinning of President Kennedy's message.

The Kennedy administration's program, while sharing many of the assumptions and proposals of the Joint Commission, differed in certain key ways. For one thing the administration proposals emphasized primary prevention and treatment in community mental health centers, moving the primary locus of treatment for the mentally ill away from the State hospitals, as opposed to using Federal institutions and funding for State hospital improvement (although in the interim existing authorization for demonstration grants to them would be continued). The population areas to be served by the community mental health centers were larger than the Joint Commission had proposed, and thus the ultimate number to be established was lower. Moreover, the concept of a community mental health "center" was broader than that of the community mental health "clinic" which the Joint Commission had spelled out.

While it recommended large increases in Federal funding, the legislation sought to specifically designate funding for construction and initial staffing of the community mental health centers, with at least 50 percent of the cost borne by the States. Further, this Federal assistance was to diminish over time. It was asserted that the centers would ultimately be financed by increased State and local funds made available through the phasing out of State hospitals and, it was hoped, by the private sector through voluntary insurance.

The Community Mental Health Center Act was ultimately passed by the Congress, but the law which was signed by President Kennedy on October 31, 1963, authorized substantially less money for construction of centers than originally was requested and also eliminated Federal support for initial staffing and operation of the centers. In any case, the National Institute of Mental Health (NIMH) immediately set out to provide for State mental health planning and to draw up the required regulations. The regulations established in 1964 state that "to qualify for Federal construction . . . grants, an applicant, which by law must be a public or private nonprofit agency, must present a plan for a coordinated program of at least five essential mental health services: inpatient services, emergency services, partial hospitalization (such as daycare), outpatient services, and consultation and educational services." There were also several services that were recommended but not required. These included specialized diagnostic services, rehabilitation, preadmission and postdischarge services for State hospital patients, research and evaluation programs, and training and education activities. In addition, the regulations mandated linkages of information, staff, and patients among those services so as to insure continuity of care.

With the regulations in effect, NIMH began to fund construction of community mental health centers. This responsibility was augmented with the passage of the Community Mental Health Center Amendments of 1963, which authorized grants to assist in paying for professional and technical personnel to staff the centers in the initial 51 months of operation. In 1967, the initial construction and subsequent staffing programs were renewed by Congress for 3 more years.

By 1970, it had become apparent that the original estimate of the length of time that community mental health centers would need Federal support had been overly optimistic. As such, the Community Mental Health Center Amendments of 1970 not only extended the Act for 3 more years, but also increased the maximum Federal share for construction and staffing grants. All centers became eligible for support over a total period of 96 months (8 years) rather than the 51 months that had originally been authorized. Those in designated poverty areas could receive more aid than others. Additional grants called "Part F Grants" were allocated for specific services for child mental health, alcoholism, and drug abuse.

In 1975, Congress passed legislation which provided for a substantial revision of the original Community Mental Health Centers Act. For the first time there was prescribed within the legislation, as opposed to simply regulations, a definition of a "community mental health center" and of the comprehensive mental health services which such a center must provide. The definition contained requirements for the organization and operation of such centers; provision of services; coordination of services with other entities and the development of an integrated system of care; staffing; availability of services; responsiveness to the community served; governing bodies; quality assurance; and related matters.

The services that a CMHC is required to provide include not only the "essential services"—inpatient services, outpatient services, day-care and partial hospitalization, emergency services, and consultation and education services for a wide range of individuals and entities involved with mental health services, including health professionals, schools, law enforcement and correctional agencies, public welfare agencies, and the like—but also specialized services for children and the elderly, assistance to courts and other public agencies in screening individuals being considered for admission to State mental hospitals, followup care for those discharged from State mental hospitals, halfway houses for those discharged from mental institutions, and programs for alcoholism and drug abuse.

To fund new centers and assist existing centers to make the transition, the new 1975 law consolidated and replaced numerous categories of aid to centers with six new grant programs: (1) planning grants; (2) initial operating grants for the support of a center's first 8 years of operation; (3) grants for consultation and education services to individuals and entities involved with mental health services; (4) conversion grants to existing centers so that they can meet the standards and requirements for the provision of services under the new law; (5) financial distress grants (no more than three may be awarded to any one center) to centers which have reached the end of their Federal support period and which demonstrate they would have to reduce the quality and number of services; and (6) facilities grants to provide for the acquisition, remodeling, leasing, and construction of facilities.

#### CURRENT STATUS

Federal funds have assisted in the initiation of 675 CMHC's (590 are actually operating in whole or in part) which, when fully operational, will make services available in areas where 93 million persons reside, 43 percent of the population of the United States.

It is difficult to describe a typical center. In terms of the catchment areas they serve, 58 percent are in urban, 17 percent are in inner city, 17 percent in rural, and 8 percent in suburban areas. They are distributed throughout most of the country: 22 percent are in the Northeast, 25 percent in the Southeast, 21 percent in the Midwest, 10 percent in the Southwest, 13 percent in the Far West, and 5 percent in the Northwest. Fifty-seven percent of the centers are serving designated poverty areas. Organizationally, they vary enormously: from freestanding facilities offering a full array of required services under a central administration to simple associations of preexisting services and facilities. Overall 19 percent are general hospital based, 3 percent are State mental hospital based, 2 percent are private psychiatric hospital based, 64 percent are hospital affiliated, and 12 percent are freestanding mental health centers.

Major differences also exist in staff composition, but some information on overall trends is available. In 1976, the full-time equivalent staff of the CMHC program nationally numbered 48,466, averaged 92 full-time equivalents (FTE's) per center, and accounted for 11.5 percent of the staff in all mental health facilities. Of these, 4.7 percent were psychiatrists, 9.4 percent psychologists, 13.9 percent social workers, 9.5 percent registered nurses, 21.8 percent paraprofessionals, 13.7 percent all other patient care staff, and 26.4 percent administrative and maintenance personnel. In recent years, the average size of center staffs has increased somewhat, in terms of FTE's, with increases mostly in administration, maintenance, and clerical personnel, psychologists, and social workers. While the average number of FTE psychiatrists has diminished, the overall ratio of professional to paraprofessional staff has slightly increased.

In 1975, the centers and their staffs served 1.6 million people, providing nearly 2 million episodes of care, or 29 percent of the total episodes of inpatient and outpatient care provided by mental health facilities. In general, patient care in CMHC's has been largely outpatient care. In 1975, 81 percent of all CMHC patient care episodes were outpatient; inpatient care and partial hospitalization comprised 13 percent and 7 percent of total patient care episodes, respectively.

Of those people admitted to care in 1975, 13 percent had a diagnosis of substance abuse, 10 percent schizophrenia, 13 percent depressive disorders, 5 percent organic brain syndrome or other psychoses, 3 percent mental retardation, 13 percent childhood disorders, 21 percent neuroses and personality disorders, and 22 percent social maladjustment, no mental disorder, deferred diagnosis, or nonspecific condition. The major trend in the diagnostic composition of the centers' clients has been the decreasing percent of those diagnoses with depressive disorders and schizophrenia, counterbalanced by an increase of those classified as socially maladjusted, no mental disorder, deferred diagnosis, or nonspecific disorder.

Out of 919,000 persons entering the CMHC system of care in 1975, 52 percent were females and 48 percent were males. The largest percentage of total additions was in the 25-44 age group, which accounted for 38.5 percent of all additions. Approximately one-fourth were under 18 years of age; 4 percent were over 65; 19 percent were 18-24; and 15 percent were 45-65 years old. Relative to their numbers in the catchment areas, children are served at roughly one-third the rate and the elderly at less than one-fourth the rate of the 25-44 age group. Almost 88 percent of all additions in 1975 were white, with the remaining 17 percent representing all other races. Over 54 percent of the additions reported weekly family incomes of less than \$100.00 among those centers reporting.

In terms of the total cost of services provided by CMHC's, in 1975 the expenditures accounted for \$776 million. In 1974 (the latest year for which data are available) the CMHC program represented only 4.2 percent of the \$14.5 billion expended for mental health care in the United States. (This can be compared to the expenditures for direct care of the mentally ill in nursing homes or in State, county, and public mental hospitals, which represented 29.3 percent and 22.8 percent, respectively, of the total costs.) Overall two-thirds of the costs of CMHC's were financed by Government sources, with 30 percent from Federal and 29 percent from State monies. An additional 30 percent is accounted for by receipts from services, with 4 percent from patient fees, 8 percent from private third-party carriers, 2 percent from Medicare, and 10 percent from Medicaid.

#### REVIEW OF EVALUATIVE DATA

An evaluation perspective necessarily involves relating information about program processes and results to the goals of that program. Thus, we examined the evaluative data about the community mental health centers program, grouping our analysis of the findings around seven general goals:

- Increasing the range and quantity of public mental health services;
- Making services equally available and accessible to all;
- Providing services in relation to existing needs in the community;
- Decreasing State hospital admissions and residents;
- Maximizing citizen participation in community programs;
- Preventing the development of mental disorders; and
- Coordinating mental-health-related services in catchment areas.

Two additional areas were also reviewed because of their timeliness and importance, even though formal goals in these areas for the CMHC program were not clearly articulated in CMHC legislation:

Providing services in as efficient a manner as possible; and

Providing services which reduce suffering and increase personal functioning to the maximum level possible.

In all these areas we found both substantial strengths and observable weaknesses.

### *1. Increasing the range and quantity of mental health services*

On the positive side, there appears to be agreement that CMHC's have increased substantially the volume of services to catchment residents, particularly outpatient care and partial hospitalization. NIMH data show CMHC episodes increasing sharply since 1966, while other facilities' episodes appear to be increasing more slowly or leveling off. Studies focusing on specific areas of the country also show that areas receiving CMHC's develop more services more rapidly than areas which do not. The CMHC's have substantially increased the amount of non-inpatient care available in the mental health system (outpatient, partial hospitalization, and consultation and education services), and newer, specialized services are now being added (halfway houses, sheltered workshops, and so on). Thus, the CMHC's have become a major factor in public mental health care.

On the negative side, there is evidence that, after the termination of Federal grants, centers begin to retrench their programs and show signs of compromising the CMHC objectives of providing essential mental health services to all catchment area residents regardless of their ability to pay. In many of the centers that have not yet achieved "graduate" status, growth is especially slow in the development of specialized services.

### *2. Making services equally available and accessible to all*

The CMHC program aimed at alleviating the "two-class" system of care, in which the well-to-do received primarily private outpatient care and the disadvantaged received custodial State hospitalization. This topic is complex, but will be restricted here to issues involving rich-poor, minority-nonminority, male-female, and urban-rural dimensions.

The majority of CMHC clients (52 percent) could be considered "poor": their family incomes are less than \$100 per week, which is just about at the official poverty level for an urban family of four. This may be partly a result of NIMH's funding more CMHC's in "poverty" areas than in "nonpoverty" areas in the earlier years of the program, but even in nonpoverty areas 48 percent of CMHC clients have family incomes below poverty level.

Male and female utilization rates were almost exactly equal in 1973: young males under 15 have higher rates, but rates for female adults are higher and thus balance the total rates.

While the large majority of CMHC clients are whites (about five-sixths), the utilization rates per 100,000 catchment residents are more nearly equal, with nonwhites (Blacks, Orientals, Native Americans) actually using the CMHC at a 30 percent higher rate (1,300 vs. 1,000 per 100,000 residents). In any case, availability and accessibility of CMHC services to minority races appear to be favorable by this utilization criterion.

In terms of barriers to accessibility, one that is important is the degree to which the community and its other caregivers are aware of the CMHC and the services it offers. It has been found that publicly identifying a CMHC with its catchment area of responsibility resulted in less sociodemographic bias in its clientele, including more nonwhites, welfare recipients, and lowest social class persons than in comparable noncatchmented services. In general, studies have indicated a fair to good awareness by residents and other caregivers as to the availability of CMHC services.

On the negative side, accessibility barriers do exist. For example, a survey of open hours for CMHC outpatient and partial care services indicated only a minority were open evenings when many employed persons would want to use those services. There is relatively thin coverage of rural catchment areas—fewer centers, less manpower, and lower utilization. Recently the relative proportion of poorer areas funded has been decreasing. Finally, there is significant underrepresentation of some minorities in many of the various professional groups working in CMHC's. This may influence both the minorities' willingness to use CMHC services and the appropriateness of the treatment given them.

### *3. Providing services in response to community needs*

On the positive side, since poverty is well established as being associated with need for mental health services, the early NIMH thrust toward funding "poverty-

area" centers was well directed toward meeting citizens' needs. A sophisticated analysis of all U.S. catchment areas in terms of needs and resources showed that in 1969, catchment areas highest in need also had the highest percentage of "adequate service structures" (31 percent) in terms of service availability and accessibility. Federally funded CMHC services undoubtedly contributed to this situation; in Colorado, for example, Federal funding helped the neediest catchment area (Northwest Denver) to establish a very large service system capable of meeting most of the need assessed.

In terms of the diagnostic population served by CMHC's, there is a strong similarity between the clients seen by CMHC's and public outpatient psychiatric clinics, with the largest groups being neurosis, schizophrenic, and personality disorders. In comparison to State hospitals, however, the clientele is less impaired in terms of fewer instances of alcoholism, schizophrenia, and organic brain syndrome. A Kansas City study compared the clients of a metropolitan CMHC with a private practice clientele. It showed that the CMHC clients were far more diagnostically diverse and were more socially disengaged. Thus, there is evidence that the CMHC program is indeed serving a needy population in the United States.

On the negative side, higher income areas have disproportionately high representation in those catchment areas recently funded for CMHC's. NIMH has long been criticized for failing to see that services were planned and funded in relation to needs; Comptroller General (Government Accounting Office) reports to Congress in 1971 and 1974 both list this deficiency. The former notes the lack of funding for CMHC's in areas of greatest need and the latter refers to programs not addressing specific catchment area needs.

There has also been a declining percentage of severe diagnoses (schizophrenia and depression) in the total program. While this appears to be attributable mainly to patterns in the newer centers, the issues involved are complex and the meaning of these data is not clear. In addition, the data on rates of additions to CMHC's suggest that children under 15 and adults over 45—and especially adults 65 and over—are underserved by CMHC's in the light of a probable need at least comparable to young adults. Rates for the elderly are less than one-fourth those for younger adults, and for children only one-third the adult rate.

#### *4. Decreasing State hospitalization*

A sizable number of studies indicate that CMHC's have had at least some impact upon reducing admissions to State hospitals. Unpublished NIMH data which show lower State hospital utilization from CMHC catchments than from the Nation as a whole are quite compelling because of the likelihood that CMHC catchments would normally generate higher rates because of their relatively less favorable sociodemographic characteristics—great poverty, more overcrowding, etc. In addition, several longitudinal studies indicates that CMHC's make a positive contribution to lowering State hospital admission rates. Finally, the data indicate that fewer psychiatric clients of the CMHC's are going to the State hospitals than was true in the past.

On the other hand, it is remarkable that the data reviewed are as mildly positive as they are, considering the importance of this objective to the CMHC program. A recent Comptroller General (Government Accounting Office) report to Congress cites as NIMH contract study to the effect that 175 CMHC's ranked "decreasing state hospital utilization" next to last in a list of 10 CMHC program goals. It does appear from CMHC additions data that the total program is moving away from caring for the most severely mentally disabled, the type most likely to spend time in a State hospital. Furthermore, the data strongly support the inference that CMHC's are not picking up State hospital discharges adequately. The absence of continuity of care for seriously ill people is a critical issue. In many instances State hospital systems seldom work with the CMHC's in providing continuity of care.

A survey of both CMHC's and various public and private agencies in the human service area conducted by one of our panel members clearly underscores the often inadequate and fragmentary services to deinstitutionalized patients. The problems that were noted basically involved the provision of little service, particularly aftercare services, including outreach, housing, and transitional residences. In addition, it was found quite common for patients to "get lost" or "fall between the cracks" and not have access to those services that do exist.

#### *5. Increasing citizen participation*

There has, especially in recent times, been considerable high-level support for citizen participation, with increasing activities headed toward this goal. In

Public Law 94-63 Congress set requirements for "representative" governing or advisory bodies; the National Council of Community Mental Health Centers has reorganized its board of directors to include "community directors" from each region on an equal footing with "staff directors"; a non-mental-health provider is now president of that organization; annual evaluation reports which incorporate citizen board and community input, and the responsiveness of the CMHC managers to that input, are now required of all CMHC's. At lower levels, interest in the topic of community participation in CMHC program affairs is also growing.

However, incorporation of citizen input into CMHC programs has been slow in coming. The Comptroller General's report of 1974 observed significant community involvement in only 2 of 12 centers reviewed. NIMH has also noted in 1977 that "boards are not sufficiently representative of the communities they serve."

#### *6. Preventing mental disorders*

On the positive side, these are studies which document that consultation and education efforts have had positive effects upon the knowledge, attitudes, and, sometimes, behavior of CMHC consultees, including police, other health professionals, and schoolteachers. CMHC consultation has long been directed primarily at schoolteachers, and this focus on children should help maximize any disorder-prevention potential of the consultation process. While evidence of impact on the children is absent from most reports, a number of behavior changes, in social interaction, learning effort, and academic performance, have been noted in a few studies.

Overall, however, this is an area of weakness. Consultation and education activities are extremely low in volume and are declining. In graduate centers facing financial constraint this is the first area to be cut back. Finally, and possibly most problematic, there is a paucity of data supporting the effectiveness of consultation in preventing mental disorders.

#### *7. Coordinating mental-health-related services*

The CMHC itself, by definition, is comprehensive (multiservice). Some early studies show intra-CMHC continuity of care. In terms of coordinating with existing catchment area services, P.L. 94-63 set new requirements for CMHC's regarding screening clients being considered for hospitalization, followup care to discharged clients, promoting rape prevention, and coordination with other health and social service agencies and State hospitals. It remains to be seen whether this legislation will have any real impact.

In general, a great deal has been written about the problems in coordination of CMHC services with other community facilities. Most recently the Government Accounting Office completed a study of deinstitutionalization which found that while a number of CMHC's were discussing individual clients' needs with State hospital caregivers, frequently there was insufficient communication which later resulted in an untimely or inappropriate admission to the State hospital. The report noted that CMHC's and State hospitals had developed independently of each other, were accountable to different authorities (State vs. Federal, local, or private organizations), tended to serve different populations, and had different funding contingencies (again State vs. Federal). There was little incentive to collaborate closely; hence, too little joint planning has been done for discharges from the State hospitals and in-community care for such persons has often been inadequate. In addition, both CMHC's and related agencies serious coordination deficiencies in response to the previously described survey by one member of our panel.

#### *8. Delivering efficient services*

On the positive side, CMHC's show a low program cost relative to total care episodes and a declining cost in constant dollars per care episode. Calculations from NIMH day on episodes of care per center and expenditures per center show that in current dollars, the average episode cost \$328 in 1971 and rose to \$355 in 1975, a 2 percent annual rate of increase. In constant dollars, corrected for inflation, the cost per episode decreased from \$328 to \$270, about a 5 percent annual decline. This was accomplished through more rapid growth in outpatient episodes (up 78 percent) and partial care episodes (up 101 percent) than in more costly inpatient episodes (up only 21 percent). Still greater efficiency is likely in the future as partial care continues its rapid expansion and further replaces inpatient stays.

In terms of administrative staffing costs, the CMHC program compares quite favorably with all other mental health facilities in administrative or maintenance staff; only 26 percent are administrative or maintenance staff, in comparison to an average of 32 percent for all other facilities.

Cost-finding techniques are now being employed quite frequently in CMHC's and other facilities, and it should not be too long before costs per unit of service for inpatient, outpatient, and partial care are available on a large scale. Some early figures for Colorado CMHC's and clinics (the latter provide only outpatient care) show that a 30-45-minute outpatient visit costs \$26, a 4-hour partial care day just slightly more, and an inpatient day about \$120. These figures are generally below the prevailing rates for similar services in the private sector in Colorado. This is to be expected, however, since CMHC's also utilize lower-paid nonprofessionals in their service delivery programs.

On the negative side, there is information to suggest unduly low percentages of clinical staff time spent on face-to-face client or consultee contact in some CMHC's. The Nader group's report on CMHC's criticized these programs for devoting nearly half of all working hours to administration, staff meetings, consultation, teaching, and other non-patient-care activities. An analysis of direct and indirect service hours in a large western CMHC showed that only 35 percent of all staff time went into client or consultee contact. Administrators have defended this percentage as reasonable considering vacations, necessary staff meetings, staff education, supervision, administration, recordkeeping, and substantial time lost to "no-shows."

#### *9. Reducing suffering and increasing people's ability to function*

An increasing number of treatment outcome studies on CMHC populations specifically are being conducted and published. Most studies show evidence of probable positive impact upon client functioning, and a few show improvement in clients to functional levels approaching those of the normal community. However, despite the encouraging trends in outcome studies, most CMHC's are quite far from being able to regularly study and document their programs' effectiveness. This is partly because the task is difficult, but it is also partly because CMHC's, not unlike other mental health facilities, have devoted few resources to evaluation.

#### STRENGTHS AND WEAKNESSES OF THE PROGRAM—AN ANECDOTAL VIEW

Since our panel reflects direct experience with community mental health centers in at least a half dozen areas of the country, we shared our own anecdotal experiences with one another. We found ourselves a microcosm of the evaluative data. Our comparison of experiences produced examples of everything from superb innovation to poor implementation. We all reported many services in danger of disappearing. Nearly all of us could identify some things being done well for substantial numbers of people, others being done poorly or not at all in the same catchment areas, and some others being done well but for very few of those who need the service in the particular area.

One panel member, for example, reported excellent but small-scale services for chronic patients, including help in socialization and in vocational referrals and some good halfway house residential programs. "Beyond these examples, there is warehousing" in her city. Services for the elderly were described as particularly weak.

Another reported that 24-hour emergency service is good in his city but only one of three centers has weekend services. That center is in financial jeopardy. He said the centers do seem to have impacted on utilization of inpatient beds but "a better job is being done on the way in as opposed to the way out."

A third stressed that his program has become a center for community activities generally and described excellent programs in the schools and for the foster care of the elderly. He said, however, that many people from outside the catchment seek care from his center because of the inadequacy of services elsewhere in the metropolitan area.

Still another reported special efforts for minorities, with stress on Asians and Native Americans as well as Blacks. He pointed with pride to an affiliated adolescent counseling program, a contract with the local school system, a grant for a neighborhood health station in the catchment area, heavy inservice training, promotional opportunities for minorities, and intensive management efforts at utilization review and peer review. He also indicated, though, that fiscal problems

have driven the consultation and education staff from seven down to one half-time person.

All members of the panel emphasized repeatedly the need to indicate that all levels of government must bear their fair share of responsibility for the weaknesses in the program, as well as the share of responsibility that is fairly attributable to the centers themselves.

#### AN ATTEMPT AT DEFINITION—IN THE PRESENT AND FOR THE FUTURE

We believe the CMHC, as an entity, partakes far more of the field of health than of any broader human service or social service definition. This is its basic identity. This should be the basic disciplinary background and orientation of its staff, even though they must necessarily be both diverse and broad in their outlook, values, and professional approach. Thus, we define the community mental health center as a health care delivery approach with linkages.

This definition is especially important when the issue of future financing is considered. We believe national health insurance, plus continued Federal categorical mental health funding, should be the backbone of future financing, with significant State and local health and mental health involvement and appropriate contributions from such areas as Title XX of the Social Security Act also fully included.

We sought, further, to define the constituent words in the phrase "Comprehensive Community Mental Health Center."

"Comprehensive" connotes an entity which offers multiple services. These are services to multiple populations. For each of those populations, the services will involve various techniques to deal with the range of needs and problems that present themselves. Further, "comprehensive" must be seen as encompassing major variations in services and techniques from community to community depending upon local needs, and variations in the delivery system.

"Community" connotes service in a defined geographical area. We strongly support maintenance of the current catchment area concept as the definitional focal point for the organization and governance of service. We think the usage of any larger defined area with regard to delivering services would do great damage with regard to accessibility and accountability. At the same time we also support—with equal vehemence—the sharing of low-volume, specialized services across catchment area lines.

"Community" also connotes connection—to other services and to the people served. Similarly, services are not community-based in the fullest sense unless there is citizen participation in their design and implementation, through appropriate governance mechanisms and otherwise.

"Mental health" is defined more than adequately in the preliminary report of the Commission. It is surely more than the absence of mental illness. One of our members has offered a synonym: "behavioral health . . . a descriptive term for all health problems that are manifested through an individual's behavior." These may be exclusive of physical health or related to it in varying degrees. He says, "Interventions for behavioral health problems may include mental health, drug abuse, alcohol, or developmental disability services. They also include a wide range of related programs such as: social services, services to the aging, child health screening, criminal justice programs and other human services."

"Center" is an entity which may be under one roof or at multiple locations, but wherein the services are all linked internally and all accountable to a board or some other legally appropriate governance structure (although some of the services may be delivered on a contractual basis by another legal entity).

At the risk of repeating, there are three key definitional points which we wish to reiterate before proceeding, even though we have expressed them previously:

Citizen input is an important element in defining what the community mental health center or service is going to do, and particularly as a primary mechanism for accountability.

Area-based governance is a key definitional element.

There is more to community mental health services than just community mental health centers.

Senator MATSUNAGA. Senator Dole, do you have any questions? It is 12:30. We are supposed to adjourn right now.

Senator DOLE. I think perhaps you have covered the basic question, which is the need and utilization of these facilities, the extent of the

coverage and what do we do next, I have tried to pursue those same issues by asking HEW to provide certain information. That study is underway.

I would ask that a copy of a list of what we hope to cover in that study, be made a part of the record. Mr. Chairman, I have no other questions.

[The prepared statement of Senator DOLE and the list he referred to follow:]

**STATEMENT OF SENATOR BOB DOLE**

Mr. Chairman, I would like to take this opportunity to thank all the witnesses who have agreed to appear before us today to discuss this most important topic, coverage of mental health benefits.

As Senator Talmadge has correctly pointed out, medicare and medicaid benefits are presently quite limited, although there has been increasing pressure to expand them and possibly alter their focus.

The questions that we must address are not simple. We must look carefully at: What services we will cover, to what extent will we pay for these services, and also who we consider to be a provider.

Mental health services are difficult to define and to measure. We must be concerned with making available services and providers that will be helpful, that will provide high quality care.

We are faced with ever-increasing health care costs and a limited number of dollars available. So we must choose wisely. To do otherwise is to possibly cheat our citizens of other much needed and appropriate services.

This discussion on mental health benefits is not a new one—it is one of many. This hearing, previous discussions, along with the results of the study I requested last year on community mental health services will all help us in making the decisions I have mentioned.

I look forward to hearing today's testimony and want to again thank all of those here.

**REPORT BY THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON MENTAL  
HEALTH AND OTHER CENTERS**

SEC. 4. (a) The Secretary shall submit to the Congress, no later than six months after the date of enactment of this Act, a report on the advantages and disadvantages of extending coverage under title XVIII of the Social Security Act to urban or rural comprehensive mental health centers and to centers for treatment of alcoholism and drug abuse.

- (b) The report submitted under subsection (a) shall include evaluations of—
  - (1) the need for coverage under such title of services provided by such centers;
  - (2) the extent of present utilization of such centers by individuals eligible for benefits under such title;
  - (3) alternatives to services provided by such centers presently available to individuals eligible for benefits under such title;
  - (4) the appropriate definition for such centers;
  - (5) the types of treatment provided by such centers;
  - (6) present Federal and State funding for such centers;
  - (7) the extent of coverage by private insurance plans for services provided by such centers;
  - (8) present and projected costs of services provided by such centers;
  - (9) available methods for assuring proper utilization of such centers;
  - (10) the effect of allowing coverage for services provided by such centers on other providers and practitioners; and
  - (11) the need for any demonstration projects for further evaluation of the need for coverage for services provided by such centers.

Senator MATSUNAGA. Thank you very much, Senator Dole, and thank you, Dr. Stewart and Dr. Wolfe.

Before adjourning subject to the call of the Chair, I would like to say that Senator Inouye had intended to be here to testify before the subcommittee. I ask unanimous consent of the committee that

his written statement be inserted into the record and likewise I ask unanimous consent that my statement be included in the record as though presented in full.

As chairman, I will say that, without objection, the unanimous consent requests are granted.

[The material referred to follows:]

#### STATEMENT OF SENATOR DANIEL K. INOUYE

Mr. Chairman: I am sincerely sorry that I am unable to personally be with you today in order to actively participate with your committee during what I am confident will be a most exciting and far reaching discussion of the mental health benefits under our Social Security legislation. However, I do appreciate your thoughtfulness in allowing me to insert this statement as part of your record. I am especially pleased that your committee is receiving testimony on behalf of S. 123, S. 233, and S. 532, legislation I introduced to provide for a greater utilization of the professional services of qualified psychologists, psychiatric nurses, and clinical social workers in the Medicaid and Medicare programs. The first of these bills was originally introduced in June 1974 and during the past 4 years each of these professions have exerted considerable effort in educating the Congress of the importance of these measures to our nation.

Under current Medicare and some Medicaid reimbursement policies, patients who are treated by these three categories of mental health practitioners cannot receive reimbursement unless the treatment is rendered under physician supervision. My bills will allow more patients to seek treatment from the many psychologists, psychiatric nurses, and clinical social workers operating as independent providers across the nation. With your permission, Mr. Chairman, I would like to submit for the record a letter from the American Medical Student Association supporting my views.

We have traditionally viewed health as being determined by physical factors, and our health care system has evolved into one which focuses on the repair of human machinery. But it becomes increasingly apparent that the social environment cannot be separated from the physical state of health. Recent studies have shown that nearly 60 percent of the patients presently going to physicians' offices for physical complaints in fact have a psychological problem, which is either the main problem or which aggravates the physical condition. Mental illness ranks fourth in the nation among reasons for bed disability. In light of these facts, health "care" which attends solely to the physical aspects of illness is a glaringly apparent misnomer.

In recent years, health care costs have risen in an unprecedented fashion, and continue to rise rapidly. Since 1950, the cost for health services to the average American have increased by 465 percent, a figure more than twice his or her increase in wages. It is estimated that health care costs will be \$233 billion by 1980. Mental health care costs will account for a significant portion of that figure. But many Americans who need mental health care simply cannot afford the help they require. Most mental health personnel and facilities are located in the most affluent urban areas of the country, driving up prices and preventing ready access to the facilities by citizens living in rural and poor areas.

I am particularly concerned about the plight of our nation's elderly. Although they comprise 10 percent of the population, senior citizens receive only 2 percent of total outpatient services. I find this shocking in that 50 percent of the elderly in non-psychiatric institutions have significant mental disabilities, and an additional 3 million non-institutionalized elderly suffer from moderate to severe emotional or mental disorders, a proportion far greater than of the population as a whole. Furthermore, the elderly constitute one-third of all residents of mental health facilities, and commit 25 percent of the nation's suicides. It has been found that as many as 20 percent to 30 percent of those labeled as senile can be treated and often helped. Frequently, timely psychotherapeutic help maintains the ability of an aged person to continue to function independently.

Many non-physician practitioners are based in small communities, providing patients an option to the physicians normally based in affluent urban areas. Recognizing this fact, the President's Commission on Mental Health suggested "strengthening resources for community based services, and creating a new class of intermediate care facilities within the Medicaid program, linked with mental health services." Freedom of choice is an important ingredient of successful mental health care. Each client or patient should have the maximum possible

opportunity to choose the combination of services and objectives appropriate to his or her needs. Unfortunately, many receiving mental health care have no such freedom. Current third party reimbursement policy daily threatens the survival of competent practitioners who are providing valuable services to people in need, and drives health care costs higher by narrowly limiting the supply of qualified providers.

It is clear to me that psychologists, psychiatric nurses, and clinical social workers have for some time been sufficiently mature to provide clinical services to their patients without the supervision of the medical profession. I am fully confident that when appropriate, independent mental health care practitioners will and do refer patients to medical doctors, just as medical doctors refer patients to mental health care practitioners. Psychologists currently function at all levels of clinical and administrative responsibility, including chiefs of statewide divisions of mental health; heads of mental health centers; directors of special programs; and as various types of clinical specialists. Psychiatric nurses are responsible for performing diagnostic evaluations, providing the entire range of therapeutic interventions, and for designing and administering effective treatment programs, and many are in positions of administrative responsibility. In addition, psychiatric nurses have often implemented innovative programs such as crisis intervention centers and psychiatric hotlines. Clinical social workers not only perform many of the above functions, but provide valuable services in ghettos and rural areas.

Over the last decade, the professions of psychology, psychiatric nursing, and clinical social work have evolved into more independent entities. All three professions have defined for public standards of competency for their mental health practitioners. Psychologists are licensed or certified by statute in all 50 states and the District of Columbia, and are recognized as independent providers under various other federal legislation. The profession of psychiatric nursing now has its own certification of clinical excellence, and clinical social workers are devising a similar system. Accordingly, I feel it is time the services of these capable and qualified groups were made accessible to those who could not afford them otherwise. The full coverage of psychologists, psychiatric nurses, and clinical social workers as independent practitioners, under Medicare will ease the shortage of mental health personnel and promote the use of their services by those who need them most.

It is my sincere hope that the committee will act expeditiously on these measures. We have done much on behalf of the physically, visibly handicapped. But to attain a health care system that is responsive to the needs of all our citizens, we must first do more for those with mental disabilities, the people suffering from invisible handicaps.

AMERICAN MEDICAL STUDENT ASSOCIATION,  
Schaumburg, Ill., July 26, 1977.

Hon. DANIEL K. INOUYE,  
*Russell Senate Office Building,*  
*Washington, D.C.*

DEAR SENATOR INOUYE: I would like to take this opportunity to express our support for S. 123, an amendment to the Social Security Act that provides for the independent recognition of Psychologists under Medicare. This bill also insures active participation by Psychologists in Professional Standards Review Organizations.

AMSA is a totally independent, medical student organization with over 20,000 members, at 121 chapters. We are dedicated to improving the health care system to make it more responsive to the needs of all people. We believe S. 123 is consistent with this goal and urge you to consider it favorably.

Sincerely,

DOUG OUTCALT,  
*National President.*

#### STATEMENT OF SENATOR SPARK MATSUNAGA

Mr. Chairman, it is common knowledge that the United States lacks adequate delivery of mental health services to its citizens. There can be no question that a careful and thoughtful review of our mental health system is needed. We need only to look at the following dismaying facts:

1. Some 6.7 million Americans are seen annually by the mental health sector; while approximately 1.6 million are under care in various mental health institutions.

2. Latest estimates place about 1 percent of the American population in the category of suffering from profound depressive disorders.

3. More than 1 million Americans have organic psychosis or toxic or neurological origin or permanently disabling mental conditions of varying causes.

4. Three percent of our schoolchildren require care for mental disorders. Ten percent need help for emotional problems.

5. By conservative estimates, at least 2 million American children have severe disabilities which, if neglected, can have profound mental health consequences for the child and family.

6. There are 40 million physically handicapped Americans, many of whom suffer serious emotional consequences because of their disabilities.

7. Ten million Americans are alcoholics, of which only 1 million are receiving treatment.

In recent studies, Mr. Chairman, 10 percent of all schoolchildren in a mid-western school setting, were discovered to be under prescription for some kind of personality altering drug. These were legitimately prescribed depressants or stimulants which school authorities and parents urge as temporary treatment for children.

Mr. Chairman, for the past few years, it has been estimated that, at any one time, 10 percent of the American population needs some form of mental health service. Presently, there is new evidence that this figure may be nearer to 15 percent of the population.

In the light of these facts, it is evident, Mr. Chairman, that our Nation is desperately in need of an improvement in the delivery of mental health services. Accordingly, I am here today to urge your thoughtful consideration of two pieces of legislation, introduced by Senator Inouye and myself, S. 123, which would provide for direct reimbursement to psychologists as providers of mental health services under Medicare, and S. 233, which would provide greater utilization of the professional services of qualified psychiatric nurses by reimbursing them for their services as providers of mental health care under both Medicare and Medicaid.

I believe we can all agree that a responsive mental health system should provide the most appropriate care for all sectors of our population in the least restrictive environment. The sad truth is that our present mental health system is woefully inadequate in its ability to render appropriate mental health services to all individuals who require these services. Not surprisingly, those whose needs are most inadequately met by our present mental health system are the elderly. While external factors, such as the lack of capacity to pay and geographical remoteness keep the elderly from obtaining proper mental health services, it is clear that our present mental health system discriminates against those in the greatest need for such services.

The incidence of mental health problems is higher among people 65 and older than in any other age group. The elderly are often subjected to multiple stresses such as mandatory retirement, a dramatic drop in income, a sense of uselessness, social isolation, and terminal illness. Although they constitute only 10 percent of our population, the elderly accounts for 25 percent of all reported suicides. Furthermore, it is estimated that 20 to 30 percent of all people labelled as "senile" have conditions that are either preventable or reversible if detected and treated early; and the elderly occupy 29 percent of the mental hospital beds but receive only 3 percent of the total outpatient services rendered for mental problems.

Currently, Medicare emphasizes hospitalization, which has been found to be unduly expensive and often ineffective in dealing with mental health problems. In addition, physicians are the only professionals given direct reimbursement for their services in the realm of mental health under Medicare. S. 123 and S. 233 attempt to improve the responsiveness and delivery of mental health services by directly reimbursing psychologists and psychiatric nurses for their services under the Medicare system. The inclusion of these two and other distinguished professional groups under Medicare can greatly expand the number of qualified mental health providers and enhance the geographical accessibility of mental health services for the elderly.

Mr. Chairman, my concern for the need of improved mental health services began when I was assigned to the Committee on Aging while serving in the House of Representatives. In 1975, I introduced H.R. 3674, the National Health

Security Act, which attempted to include comprehensive mental health coverage as an essential element in an effective National Health Security Act. My concern is even greater today.

It is my hope, therefore, that the testimony heard today from various professional groups will assist this Subcommittee on Health in answering many important questions pertaining to the role of the Federal Government in providing an adequate delivery of mental health services to all of our nation's elderly and poor who are in need of such services. It is my hope also that the dialogue initiated today will launch this Subcommittee on a careful and thoughtful review of what I believe to be one of our nation's most pressing problems, the delivery of effective mental health services to all Americans who require these services.

Thank you.

Senator MATSUNAGA. Subject to the call of the Chair, the subcommittee now stands adjourned.

[Thereupon, at 12:30 p.m., the subcommittee recessed, to reconvene subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF THE UNITED CEREBRAL PALSY ASSOCIATIONS, INC., SUBMITTED BY  
E. CLARKE ROSS, DIRECTOR, UCPA GOVERNMENT ACTIVITIES OFFICE

#### STATEMENT OUTLINE

##### *Topic*

Introduction: Title XX And UCPA Services To Persons With Disabilities.  
The Role Of Social Services In Supporting Persons With Disabilities.

Item: Title XX Benefits In New York.

Item: Title XX Benefits In Kansas.

The Impact Of The Title XX Ceiling On Persons With Disabilities.

Item: Ceiling Impact In Ohio.

Item: Ceiling Impact In Georgia.

Item: Ceiling Impact In Pennsylvania.

Conclusion.

Appendix Material

May, 1977 *Columbus Dispatch* article "Fund Cutback Hurts Palsy Victims."  
May 5, 1977 UCP of Columbus and Franklin Counties Correspondence To The

UCPA Governmental Activities Office.

March 7, 1977 UCP of Columbus and Franklin Counties Correspondence To  
The Ohio Department of Public Welfare.

December 5, 1977 *Cincinnati Post* article "The Title XX Disaster."

#### INTRODUCTION: TITLE XX AND UCPA SERVICES TO PERSONS WITH DISABILITIES

United Cerebral Palsy Associations, Inc. appreciates this opportunity to address the issue of increased funding for services under Title XX of the Social Security Act. Many of our nearly 300 UCPA affiliates across the Nation serve individuals with cerebral palsy and related disabilities through programs receiving Title XX funding; and it is no understatement to maintain that without this vital source of support many of our programs would have to be curtailed or discontinued altogether, causing tremendous hardships to the thousands of consumers we assist daily. Of our affiliates combined 1977 income of \$50,476 million, \$20,369 million or 40% were derived from governmental grants and contracts; the Title XX purchase-of-service contract is one of the more prominent forms of governmental support for our affiliates.

The objectives of our written statement are threefold: (1) To demonstrate the importance of Title XX social services in supporting persons with moderate and severe disabilities, (2) To cite several situations in which persons with cerebral palsy are being deprived of needed services as a direct consequence of state retrenchment in Title XX policies and programs, and (3) To supplement the oral testimony of our sister agency, the National Association for Retarded Citizens, in order to demonstrate the common concern of the disability movement with Title XX service delivery.

UCPA strongly supports the immediate enactment of H.R. 12973.

#### THE ROLE OF SOCIAL SERVICES IN SUPPORTING PERSONS WITH DISABILITIES

One of the primary programmatic goals in the disability movement today is to prevent unnecessary institutionalization and provide residential and other community living alternatives to institutions. The freedom and opportunity to choose where to live in the community is the overriding objective to these efforts. Social services are intended to assist disabled individuals in meeting the needs of everyday living and to obtain access to other resources. They include such services as counseling, day care and adult activity centers, special transportation, information and referral, outreach, social-developmental and recreation, and attendant care/homemaker activities.

##### ITEM: TITLE XX BENEFITS IN NEW YORK

The impetus behind the Finance Committee hearing is Senator Daniel Patrick Moynihan's interest in seeking clearer answers to some important Title XX questions related to the distribution formula and income maintenance relationships. The distinguished Subcommittee on Public Assistance Chairman should be aware of the many benefits the program offers to severely disabled persons in his home state of New York.

Willowbrook is one of the most infamous institutions for the developmentally disabled in the world. Efforts have been taking place over the last several years to "deinstitutionalize" some of these residents by providing community support programs. UCPA of New York State is currently utilizing Title XX funds to provide homemaker services for 85 former residents of Willowbrook who now live in supervised apartments throughout the five boroughs. Without the homemaker service it is highly probable that these persons would have to resort to institutional care.

This is just one illustration of the role of Title XX in providing important services to the severely disabled in New York state.

##### ITEM: TITLE XX BENEFITS IN KANSAS

Title XX plays an absolutely essential role in Kansas for a population which cannot receive necessary support services from any other funding source. The services offered by UCP of Kansas prevents institutionalization and reinstitutionalization.

Title XX supports 26 severely physically disabled persons who reside in a community living arrangement program. Services provided are food services, specialized transportation, and physical support services. These training services support activities of daily living to allow the disabled persons to reach higher levels of functioning and individual independence.

UCP of Kansas has 14 other severely physically disabled persons awaiting placement in their living arrangements program. Successful placement depends upon expansion of the existing Title XX contract.

Title XX also supports 15 individuals in the ELKs Training Center sheltered workshop. These persons have been determined by Vocational Rehabilitation too severe for VRM's employment oriented services.

The Title XX ceiling has had its effect on these consumers. In addition to the residential waiting list, the state has cut UCP's reimbursement rate from \$17.44 per client day to \$16.50 for the workshop and \$12.00 for the residential program. This is occurring at a time of inflationary programmatic cost increases.

#### THE IMPACT OF THE TITLE XX CEILING ON PERSONS WITH DISABILITIES

A recent National Governors' Association state responses to Representative Donald Fraser's Title XX survey indicated some unfortunate programs cut-back trends:

(1) Of the 37 states responding, 16 have terminated or reduced purchase of service contracts.

(2) 9 states have consciously changed the eligibility criteria to limit the number of participants in a program or have specifically not changed eligibility criteria to continue to include people who become ineligible as a function of increased public assistance programs.

(3) 9 states have simply eliminated specific service categories. The NGA survey states that "these specific cutbacks have usually taken place in the areas affecting the handicapped (developmentally disabled, mentally retarded, and mentally ill), the elderly, and protective services for children and adults.

The NGA survey documented that Title XX programs for persons with disabilities have been discontinued or cutback in Colorado, Idaho, Kansas, Montana, Nebraska, New Jersey, Ohio, and West Virginia.

The remainder of the UCPA statement will cite examples of these cutbacks on programs operated by UCPA affiliates.

#### ITEM : CEILING IMPACT IN OHIO

The state of Ohio has decided to reapportion Title XX monies to rural counties without increasing state subsidies to make up the difference in those urban areas in which income was lost. This policy, traceable in large measure to an insufficiency of Title XX funds, has had a catastrophic effect on a number of our affiliates in the state.

*UCP of Columbus-Franklin Counties.* Two-thirds of this affiliate's \$600,000 budget is composed of Title XX contract reimbursements. As the result of Ohio's decision to divert funds away from urban areas the affiliate will be required to curtail or discontinue services to many of its clients (cf. Appendix I). A redefinition of adult day care imposed by the state in an effort to reduce its Title XX commitment even further will eliminate services for 174 of the 200 adults currently served by the affiliate (cf. Appendix II and III).

*UCP of Metropolitan Dayton.* Due to the reallocation of State Title XX monies to rural areas, Montgomery County received only 50% of the funds for which it had certified need, and which it had anticipated. As a result, many social service programs in the county were cut back or suspended, including that of UCP of Metropolitan Dayton. This affiliate's contract to provide adult day care and related transportation services was slashed from \$175,000 to \$75,000—on nine days' notice. While private sources have assisted the affiliate in offsetting some portion of its financial loss, the resulting budget is still inadequate to fund the program at the level of operation which both clients and staff had initially been led to expect. While at the present time no staff members have had to be let go, the prognosis for the future is extremely uncertain.

*UCP of Cincinnati.* Because, like affiliates of many voluntary health agencies, this affiliate's budget relies heavily on Title XX monies, its programs are in serious jeopardy. Approximately \$175,000, or one third of its total budget, results from Title XX contract activities. As a consequence of a 38 percent rollback in Title XX funding for Hamilton County (cut from an expected \$6.1 million to \$3.8 million), the affiliate's budget suffered a \$75,000 loss in revenue, resulting in significant staff reductions and truncation of its adult program (cf. Appendix IV). On a broader plane, the county as a whole suffered crippling cuts in its social service programs, of which the following are indicative:

Program	Percent fiscal year 1977 budget
Adoption service-----	88
Legal services-----	9
Special services for blind-----	59
Development services for disabled children-----	41
Health and related services-----	67
Disabled adults-----	52

#### ITEM : CEILING IMPACT IN GEORGIA

UCP of Macon and Middle Georgia has operated a Title XX service program for 50 severely and multiply disabled adults for several years. Because of budgetary constraints the Title XX rules have been changed so that only persons with IQ levels of 70 or less may continue to be served. This change in Title XX has left 8 non-retarded persons with cerebral palsy without services. UCPA trusted the Title XX agency in serving the severely disabled; now, the agency established to help meet the needs of persons with cerebral palsy, can not serve the non-retarded individual with cerebral palsy.

## ITEM : CEILING IMPACT IN PENNSYLVANIA

In Pennsylvania the Department of Public Welfare provides matching state funds for Title XX programs directed toward individuals who are mentally retarded, blind, or qualified for a number of the targeted service categories. It provides no matching monies for individuals who are strictly physically disabled.

Like many states in the early 1960's Pennsylvania passed a fairly comprehensive bill providing services to individuals with mental retardation or mental health problems. For the past fifteen years it has been necessary to seek funds for the physically disabled through the back door of some other funding source—funds for the blind, funds for the mentally retarded, funds for the poor—always another disability or condition that a consumer had to claim in addition to physical disability in order to receive services.

The limitation imposed by fiscal constraints of the Title XX program in Pennsylvania have forced the state to prioritize its disabled residents in an unbalanced manner which seriously compromises the effectiveness of its social services program, and raises the question of whether in fact physically disabled individuals are being discriminated against on the basis of handicap. While we do not challenge a state's right to set Title XX funding priorities, we are compelled to voice our frustration at a funding system which on the one hand stimulates the demand for services while on the other forces administrative agencies to make agonizing, often questionable exclusivist choices regarding the populations they can afford to serve.

For example, UCP of Lackawanna County (Scranton) receives \$246,000 in Title XX subcontract support for a wide variety of services to developmentally disabled children and adults who are mentally retarded. However, at least a third of the adult case load are non-retarded and thus not eligible for Title XX funding given Pennsylvania's current service priorities. How would you feel telling a parent that their severely disabled child could receive services only at cost to the parent and the voluntary agency because the child was not retarded knowing that other families received comprehensive services with public support in the same agency program?

## CONCLUSION

There is no question that an extension of the Title XX ceiling at the levels indicated in H.R. 12973 is essential if the federal government is to continue to exercise its lead in encouraging the provision of social services to all individuals requiring them. Moreover, as is evidenced by the examples cited in the preceding pages, a legislative initiative to provide interim fiscal assistance to state and local governments during the transition period is equally necessary. Without adequate financial backing no social service program, whether administered through public or voluntary nonprofit agencies, will be able to meet the needs of persons with disabilities, or indeed anyone requiring such assistance.

The Title XX program has been instrumental in creating the momentum for enhanced local service delivery, and as a result millions of individuals have benefited from federally supported social service activities. As a result of federal efforts to date the essential components of a successful system—the staffing, facilities, equipment, clients—are already in place. What is lacking is the assurance that the programs so enthusiastically and effectively begun will have the funding they require to continue. Without that assurance the quality of life for many disabled individuals will have been permanently—and tragically diminished.

## FUND CUTBACK HURTS PALSY VICTIMS

(By Stephen Berry)

Many cerebral palsy victims in the Columbus area will "sit at home and rot" if the Ohio Department of Public Welfare (ODPW) follows through with its plan to cut Franklin County's share of federal Title XX money, a United Cerebral Palsy official says.

Approximately 200 cerebral palsy victims participate daily in adult programs of the United Cerebral Palsy of Columbus and Franklin County Inc. (UCP), 2144 Agler Rd.

But the center faces the dim prospect of trimming its services if the county's share of Title XX money is cut, Eugene Cuticchia, executive director, said.

One client, Jim, 28, works in the center's print shop 2½ days a week making calling cards, graduation announcements, and other notices. He earns \$20 to \$25 a month.

Jim also learns from instructors how to cope with death, budget his own money, and socialize with others. He is dependent on the center's fleet of 12 leased vans for transportation because he is confined to a wheelchair.

Although Jim can communicate with others, his speech is unintelligible and he has limited use of his hands.

Cuticchia said Jim is lucky, though, because he lives independently with his wife, who has a part-time job. If Title XX money is cut back, other clients might not fare as well.

"I have other clients who, if Title XX is cut, will just sit at home and rot," Cuticchia said.

The ODPW plans to cut the Franklin County Welfare Department's share of Title XX money by about \$1.74 million next fiscal year. And, if smaller counties begin spending more Title XX funds, Franklin County's share of the social services money could decline by as much as \$5.2 million from its present level.

Of a projected 1977 budget for the adult UCP program of \$611,793, a healthy \$421,852 is needed from the federal government through Title XX to maintain the program, Cuticchia said. The balance of operating funds comes from the United Way allocation and donations.

"Everyone has a right to work, recreation and self-improvement," Cuticchia said. "We're trying to fill that void in these people's lives."

The center, which has a waiting list, currently serves approximately 200 multi-handicapped persons. The crippling disease is caused by brain or other nervous system damage before birth, at delivery or early in life. While cerebral palsy strikes early, most of its victims live normal life spans, Cuticchia said.

#### TALK ON SCHOOLS SET

State Sens. Michael Schwarzwalder and Theodore Gray and State Reps. Lawrence Hughes and Mack Pemberton will speak at 8 p.m. Thursday at the Board of Education office, 465 Kingston Ave., Grove City. They will discuss school legislation and school funding.

Most clients, who range in age from 18 to 70, will remain in the program until they die, move out of the community, or perhaps enter a nursing home, Cuticchia said.

Eighty of the 200 clients are confined to wheelchairs and thus depend on the center's vans for all their transportation needs. The vans take them to and from the center, shopping, to health clinics, and other chores such as for banking.

Because of transportation problems and architectural barriers in the community, few of the center's clients ever find jobs, Cuticchia said. Six persons this year got part-time jobs cleaning the center under a maintenance contract Cuticchia negotiated. It was an unusual case.

Cuticchia said a 10 percent cut in Title XX money would mean reducing the 70-member staff by eight persons, for example.

"It's immoral, an injustice to take a client out of his home, give him programs and then take them away," Cuticchia said. "It's taken us five years to build up clients to where they feel like first class citizens. There are just not enough private dollars to provide the services mandated by the government and needed by our people."

UNITED CEREBRAL PALSY,  
OF COLUMBUS AND FRANKLIN COUNTY,  
*Columbus, Ohio, May 5, 1977.*

MR. E. CLARKE ROSS,  
*Director, UCPA Governmental Activities Office,*  
*Chester Arthur Building,*  
*Washington, D.C.*

DEAR CLARKE: The frustrations of surmounting the maze of governmental and private bureaucracies are becoming a most severe threat to the provision of direct services to clients by this Agency. As you may recall, this Agency uses its annual United Way allocation as matching monies for a Title XX Contract with the local Welfare Department. Presently, most services are being provided under

the Service Code : Day Care for Adults. This service code has been broad enough to permit us to provide comprehensive spectrum of services.

Now, the Ohio Department of Public Welfare has redefined Adult Day Care, effective July 1, 1977 as follows:

Care for the day or a portion thereof for adults who continue to reside in the community, outside of institutional care, but are in need of supervision while family members or other caretakers are at work and are out of the home. The purpose of the service is to enable the adult to remain in the community. The setting may be a day care home or a group center . . . Program is designed to encourage maximum use of personal capacity particularly in relation to self-care and socialization.

Of the 200 adult clients we are serving all but twenty-six (26) would become ineligible since twenty-seven (27) live independently, sixty-nine (69) in state institutions, thirty-two (32) in nursing homes, four (4) in group homes and forty-two (42) with retired or non-working parents or guardians.

From the Federal Regulations, it is clear that the Ohio Department of Public Welfare, as administrator of Title XX, has the mandate to regulate service provision. In Ohio there is an on-going struggle between Welfare and the Department of Mental Health and Mental Retardation which receives the top third of Title XX monies. Both departments are aware of the bind this imposes upon our Agency and laud the services we provide but neither seems willing to offer a solution. This only serves to emphasize that the thrust in Ohio is to serve the Mentally Retarded population to the exclusion of the remainder of the Developmentally Disabled population.

The local welfare department, Franklin County, continues to be our lone advocate. Through their efforts we should be able to continue providing some services. It has been suggested that appropriate action be initiated which would result in a service code in Title XX designed to address the special needs of our client population.

We would welcome your advice and suggestions in regard to the approach we should be taking. Our state and local legislators have been apprised of the problem and are supportive of our cause.

Sincerely yours,

EUGENE A. CUTICCHIA,  
*Executive Director.*

UNITED CEREBRAL PALSY  
OF COLUMBUS AND FRANKLIN COUNTY, INC.  
*Columbia, Ohio, March 7, 1978.*

MADELENE HERTZMAN,

*Chief, Bureau of Adult Services, Ohio Department of Public Welfare, State Office Tower, Columbus, Ohio*

DEAR MS. HERTZMAN: Since September 8, 1972, this Agency, United Cerebral Palsy of Columbus and Franklin County, Inc., has been providing direct social services to the cerebral palsied and multi-physical handicapped of Franklin County through purchase of service contracts with the Franklin County Welfare Department. Under the terms of the present Title XX Contract, as well as those of prior Title IV A and Title XX contracts, the bulk of services being provided to the 200 adult clients of the Agency are provided under the Service Code 110—Day Care for Adults.

The presently existing definition of Day Care for Adults—

Personal care for part of a day for persons in need of supervised care in a protective setting approved by the state or local agency. It may be a family home or a congregate setting. Individuals may be helped to move from withdrawn isolation to interpersonal communicating and relating to others, to develop interest in the surroundings so that each can utilize his or her potential for self-dependence.

Meals may be provided so long as less than three (3) meals per day are included and such meals are not designed to meet the full nutritional needs of the individual. Physical examination may be included when it is a requirement for participation in the service and cost is not reimbursable under Titles XVIII or XIX.

Provides that a wide range of activities can be provided for the least restricted number of qualifying clients whose eligibility for services is determined by the Franklin County Welfare Department. The focus of this program of services is the actualization of the potential for self-dependence of each individual client.

Success and quality of this service provision has been measured in terms of the personal growth and development of the Agency's clients resulting in their placement in more appropriate living arrangements. Twenty-seven clients now live independently in their own apartments, 32 live in nursing homes, 4 in group homes, 68 in their parents' or guardians' homes, 69 in state institutions. This movement from least restrictive to less restrictive living accommodations has enhanced the process of deinstitutionalization in which we all, both the public and private sectors, have a vested interest.

It has now come to our attention that the proposed definition of Day Care for Adults—Care for the day or a portion thereof for adults who continue to reside with own family, but are in need of supervision while family members are at work and are out of the home. The purpose of the service is to enable the adult to remain in the community. The setting may be a day care home or a group center. One full meal and snacks may be provided, however, the full nutritional needs of the individual are not met. Physical examination upon acceptance into the program may be included if the cost is not reimbursable under Titles XVIII or XIX. Program is designed to encourage maximum use of personal capacity particularly in relation to self-care and socialization—would place severe restrictions upon the number of clients this Agency could serve. The new definition would eliminate the provision of services to the following :

	<i>Clients</i>
(1) All those living independently-----	27
(2) All those living in institutions-----	69
(3) All those living in nursing homes-----	32
(4) All those living in group homes-----	4
(5) All those living with parents or guardians who are nonworking or retired -----	42

The end result would be that only 26 clients living with parents who are employed could be provided the services this Agency has developed over the past five years to meet the needs of this highly discriminated against segment of the population.

We are certain that the intent of the revision of the definition of Day Care for Adults was not to restrict but rather to extend services. It would seem, from a perusal of the proposed definition, that this definition has been adapted from the definition of Work-related Day Care for Children. This may well serve a definite need and purpose but the restrictive nature of the definition of Day Care for Adults would reimpose a definite hardship on the cerebral palsied, multi-physically handicapped and their parents whose plight has only too recently begun to be addressed.

Further, and most importantly, in terms of the new restrictive nature of the definition, the severely handicapped individual is relegated to the role of dependent "child", for life, thus closing the avenues to maturation, a violation of the rights of individuals living in our society. This is indeed a gross injustice.

Because of the implications of such a restrictive definition of Day Care for Adults, we find it necessary to call these facts to your attention and to hereby lodge our protest. This Agency stands ready to defend its programs of service delivery and to advocate the cause of the clients we are chartered to serve. We are at your disposal to clarify our stand and to answer any questions you might have in this most serious matter.

Sincerely,

BETTY M. ROGERS,  
President, Board of Trustees.  
EUGENE A. CUTICCHIA,  
Executive Director.

#### TITLE XX DISASTER

To know what the recently announced cutbacks in Hamilton County's Title XX funding signify, it is almost necessary to know Ed Jones.

Ed is a man in his early 20s confined for life to a wheelchair. He has difficulty speaking, though never thinking or emoting, which is why he cherishes his programs at the United Cerebral Palsy Center. Five days a week Ed takes a course in letter-writing; he checks silk-screened Christmas cards for ink spills, and he swims and bowls. Through the center, he finds some fulfillment in life.

Now, because of unanticipated and enormous cuts in the monies that pay for programs such as these, people like Ed may be abandoned. Less than two weeks ago, state officials announced to local welfare workers that a \$2.5 million slashing of the original \$6.3 budget for fiscal 1977-78 is virtually irreversible.

Title XX, to recap the complex legislation, is an amendment to the Social Security Act that deals with social services for the aged, blind, disabled and their families. Passed in January 1975, it provides federal dollars for the states according to formula based on population and per capita need (three federal dollars for every one state and local dollar). But—and here's the kicker—it is a reimbursement program. Only after the state has spent the money can it claim reimbursement from the feds.

In the first two years that Title XX money was available in Ohio, Hamilton County tried to establish carefully the needs for various services before committing any dollars. Like much of Ohio, the county did not spend all of the Title XX money immediately available to it.

For fiscal year 1976-77, Hamilton County was allocated \$6,263,000. By March of 1977, however, when allocations for the next fiscal year were being set, the county was still perfecting its methods. It knew what it was going to do with the money but it had not actually committed all of it.

So what happened? State officials looked only at expenditures through March, presumed that Hamilton County was not going to use all of its funding and chopped its future allocation severely.

By the time Hamilton County learned what had happened—on July 1, the first day of the new fiscal year—at least 33 Community Chest agencies and 12 non-Chest agencies had made important funding commitments for the coming year. These commitments were based on the assumption that the new allocation would approximate last year's \$6.2 million.

Since July 1, Chest and local community officials have been scrambling to patch up the damage, but without success. Unless something dramatic happens, Ed Jones may well see some of his program cut, and any future Ed Jones may remain locked out.

What hurts the most, according to Community Chest spokesmen, is the size of the local cut—38 percent—when comparable counties in Ohio received little or no cuts. Lucas County (Toledo) lost 13 percent of its funding; Franklin County (Columbus) lost 15.6 percent; Cuyahoga County (Cleveland) lost none. Local agencies have been penalized, it appears, for exercising caution in the expenditure of federal funds.

What will happen? With financial juggling, some prayer and the possibility that other Title XX recipients won't use all the money that is rightfully theirs, Hamilton County may limp through until May. But unless the state reallocates the county will not fulfill its commitments through June.

In fairness, the state should reallocate right now, and put an end to the uncertainty. If, another year, more of Ohio's 88 counties claim enough so the largest recipients must be cut again, so be it. Foreknowledge will allow time to adjust. This time around, Hamilton County is stranded.

NORTH CENTRAL HEALTH CARE FACILITIES,  
Wausau, Wis., Aug. 11, 1978.

Senator GAYLORD NELSON,  
U.S. Senate,  
Washington, D.C.

DEAR SENATOR NELSON: I have been informed that there will be a public hearing conducted by the Subcommittee on Health of the Senate Finance Committee on August 18th. At that time the committee will be accepting testimonies regarding Medicare and Medicaid. I would like to take this means of refreshing your memory pertaining to our concerns.

As you may recall, when you participated in the dedication of our new facility last February, I expressed to you, Secretary Califano, and Congressman Obey my concerns of the discrimination in the present Medicaid system. Under Title XIX of the Social Security Act, Section 1905(a)(14) it states, "inpatient hospital services . . . for individuals 65 years of age or over in an institution for . . . mental diseases" will be reimbursed under the Medical Assistance Program. This denies payment for persons between 21 and 65 years of age (another section allows payment for those under 21) in "institutions for mental diseases."

No age limitations are placed on other inpatient hospital service sites including general hospitals.

This discriminatory language creates an irrational advantage for general hospitals in the delivery of mental health services. The inpatient services provided by "Free-standing mental health facilities" are usually equal to or superior in quality to those offered by general hospitals and are often offered at less cost. As an example, our present inpatient daily cost, which is all-inclusive, including medical and psychiatric services, is \$106.00 per day, with an average length of stay of 14 days. Another concern we have in this matter, especially as it pertains to Wisconsin, is that there is a large portion of the state which does not have psychiatric services readily available in a general hospital. Therefore, they must rely upon community mental health centers which are free-standing, and the burden of the costs are then primarily placed upon the local unit of county government. And, as you are aware, this cost is then passed on to property tax.

Your continued assistance and understanding in this effort is greatly appreciated. I would certainly welcome the opportunity, if you feel it is warranted, to meet with you to discuss this matter either prior to or on August 18th, or possibly you could have this introduced into the record.

I am certainly looking forward to hearing from you, and again, our sincere appreciation for your consideration.

Sincerely yours,

PETER DESANTIS,  
*Executive Director.*

GERONTOLOGICAL SOCIETY,  
*Washington, D.C., September 1, 1978.*

The Gerontological Society, a national organization of researchers, clinicians, educators and practitioners in the field of aging submits this written testimony for the record with regard to mental health coverage under Medicare and Medicaid.

Approximately 14% of persons over 65 years old live on an income below the Federal poverty level. With retirement, income drops by one-half to two-thirds. With increasing age, assets are used up leaving the elderly on fixed incomes even less able to meet health crisis.

When such health crises occur, the Medicare-Medicaid programs provide a distinct service; but in so doing, it places excessive reliance on the formal, institutional solution to health care problems. This has hindered the growth of home-based alternatives. Because of restrictions of types of services and types of providers that are legally reimbursable, elderly may not receive needed care while remaining in their own homes. Without a well coordinated system of health and mental health services in the community, many frail elderly too often find themselves permanently and inappropriately institutionalized.

There has been a long history of exclusion of the mentally ill from receiving the same benefits from basic health care and welfare programs. Coverage for mental health care should be equal to that for physical health care, for both acute and chronic illness.

Staff development and inservice training costs in long-term care facilities should be allowable items under Medicare and Medicaid within reasonable limits. In this way trained mental health professions could provide more consultation and education services to direct care providers, the obvious goals being increased staff skills and improved patient care.

Mental health services provided by professionals in addition to psychiatrists should be eligible for reimbursement when their care is supportive and part of a collaborative approach in a comprehensive treatment plan.

Psychiatric evaluation and treatment as out-patients as well as coverage for psychoactive medications could avoid unnecessary hospitalization at greater cost.

It would be a great benefit to all parties if the cost of a telephone in an elderly person's home were covered by Medicare upon the prescription of a physician.

If Medicaid reimbursement were restricted to those who require nursing home care for bona fide medical/psychiatric reasons, the health dollar would not be spent to support housing needs.

In summary, mental health care services for the elderly have been, until now, a low priority budget item. Medicare and Medicaid have discriminated against the

mentally ill and forced unnecessary institutional care when the same services might have been provided at lower cost and greater humanity in elderly person's homes. The share of the health care budget for mental health services falls short of well documented needs.

Attempts to address these inadequacies include the retraining of existing staff in community mental health centers and long-term support facilities to learn the skills necessary to care for elderly; increasing the number of locations at which mental health services are available and assuring the frail elderly consumer of access to these services; improving the quality of care; and working at all levels to increase the funding to support these efforts.

BENNETT GURIAN, M.D.,

*Member, Public Information Committee Gerontological Society and Director of Geriatrics, Massachusetts Mental Health Center, Boston Mass.*

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UNIVERSITY OF HEALTH SCIENCES/THE CHICAGO MEDICAL SCHOOL,  
North Chicago, Ill., August 31, 1978.

HON. HERMAN TALMADGE,  
*Chairman, Health Subcommittee, Senate Finance Committee, Senate Office Building, Washington, D.C.*

DEAR SIR: I am writing in response to your recent hearings devoted to coverage of mental health services by Medicare and Medicaid. I wish to support Martin Gross' contention that psychotherapy as generally practiced is an ineffective treatment modality and should not be covered by third party payment. There are literally dozens of studies that support this viewpoint and they have been reviewed by Eysenck (1), Spitzer and Klein (2), and Bergen and Garfield (3).

As a Chairman of an academic Department of Psychiatry and as an Acting Chairman of a Department of Psychology, I also wish to underscore what I believe are major differences between *Psychological Services* and *Psychiatric Services*. The latter is traditionally a facet of medical care and deals with the understanding and medical treatment of individuals with brain disease or dysfunction that is manifested by major behavioral change. The major mental illnesses (manic-depressive disorder, schizophrenia), age-related dementias, certain forms of epilepsy, and the serious neuroses, fall into this general category. I believe inpatient and outpatient medical psychiatric care of individuals with these conditions should be covered by third party payment. Psychological Services concerning the evaluation of brain function (psychological testing) and the modification of maladaptive non-disease induced behavior (e.g., phobias) are, I think, also appropriate for coverage because they provide diagnostic aid on the one hand and demonstrable symptom relief on the other hand. However, psychodynamically oriented psychotherapy (group and individual) has no proven effectiveness either for behavioral disease or for behavioral maladaption and I believe the country's limited resources could be better spent than to support and perpetuate this therapeutically worthless treatment.

MICHAEL A. TAYLOR, M.D.,  
*Professor and Chairman.*

- (1) Eysenck, H. J. *The Effects of Psychotherapy*, New York, The International Science Press, Inc. 1966.
  - (2) Spitzer, R. L., Klein, D. F. (eds). *Evaluation of Psychological Therapies*, Baltimore, The Johns Hopkins University Press, 1976.
  - (3) Bergen, A. E., Garfield, S. L. *Handbook of Psychotherapy and Behavior Change*, New York, John Wiley & Sons, 1971.
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AMERICAN MEDICAL ASSOCIATION,  
Chicago, Ill., September 1, 1978.

Re: Mental Health Services Under Medicare and Medicaid.

Hon. HERMAN E. TALMADGE,  
*Chairman, Subcommittee on Health, Senate Finance Committee, Dirksen Senate Office Building, Washington, D.C.*

DEAR SENATOR TALMADGE: The American Medical Association is pleased to submit its comments regarding the provision of mental health services under the Medicare and Medicaid program.

The Medicare and Medicaid programs were designed to provide for a wide variety of health care benefits, both inpatient hospital and outpatient physician services for the elderly and the disabled under Medicare and for certain low income groups under Medicaid.

With the exception of end-stage renal disease, psychiatric services are the only covered medical services and hospitalization subject to rigid limits under Medicare. Section 1812(b)(3) of the Social Security Act places a maximum lifetime coverage limit on inpatient days for psychiatric hospital services at 190 days. Similarly, Section 1833(c) limits reimbursement under Part B of Medicare for physician services by limiting reimbursement for eligible psychiatric expenses to a maximum of \$250.00 per year. This fixed limit has not been increased since the Medicare law was passed. Reimbursement for physician services under Medicare, other than for psychiatric services, is placed at 80% of the Medicare determined reasonable charges with no maximum limitation on eligible expenses and there is no lifetime limit on inpatient hospital stay benefits similar to that for psychiatric services.

Under Medicaid, states are not even required to provide any coverage for inpatient psychiatric services for those between the ages of 21 and 65.

The American Medical Association has long supported the elimination of the discriminatory coverage of psychiatric and somatic conditions. At its Annual Meeting in 1975, the American Medical Association's House of Delegates spoke to the need for parity of benefits for all physician and hospital services under federal health programs. This policy is based upon the longstanding recognition that emotional or mental illnesses can be as incapacitating and debilitating as physical illnesses, and are amenable to medical treatment. This policy was reiterated at the latest Annual Meeting of the Association in June.

Psychiatric illness is not unlike physical illness. There are acute disorders that can be treated in a relatively brief period of time, usually on an outpatient basis. There are also chronic and relapsing conditions that require maintenance treatment over an extended period of time, either on an outpatient or inpatient basis. What is not widely appreciated is that new therapeutic techniques, including the judicious use of psychotropic medication, have shortened hospital stays, or obviated the need for hospitalization altogether in many psychiatric cases, thus reducing the cost-benefit ratio.

The American Medical Association supports parity of benefits for the treatment of emotional and mental illness with those benefits provided for other medical indications, not only under federal health care programs but also for private insurance and government employee coverage. AMA's proposed comprehensive health insurance program (S. 218, H.R. 1818) also provides for parity of hospital and physician coverage between psychiatric and other medical services.

The American Medical Association urges modification of the Medicare and Medicaid programs to eliminate the present limits on coverage of psychiatric treatment.

Very truly yours,

JAMES H. SAMMONS, M.D.

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STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AFL-CIO

SUMMARY

The American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO, represents 1.6 million public workers, including 140,000 employees in mental health institutions and 80,000 in mental retardation facilities.

The most serious problem in federal mental health care reimbursement is the inequitable exclusion of Medicaid coverage for persons aged 21 to 65 who are "inmates of public institutions." This exclusion has contributed to widespread abuses of mental patients who are "dumped" out of state mental hospitals in order to save money. "Dumped" patients are subsequently "reinstitutionalized" in sub-standard, private (often proprietary) nursing homes, where they qualify for Medicaid coverage.

These widespread abuses have been well documented in reports by the Senate Special Select Committee on Aging, the General Accounting Office, the President's Commission on Mental Health, the HEW Inspector General, the Assistant Surgeon

General and numerous state officials,<sup>1</sup> as well as by mental health experts, journalists and AFSCME.

AFSCME recommends the following amendments to title XIX of the Social Security Act:

1. Medicaid mental health coverage must be extended to all eligible patients in public institutions.
2. There must be strict accountability and control over all types of facilities serving mental patients who qualify for Medicaid.

#### THE PROBLEM

Section 1905(a)(17)(A) of the Social Security Act (42 USC Section 1396d) prohibits Medicaid reimbursement for mental health care of an otherwise-eligible recipient if that person is an "inmate of a public institution (except as a patient in a medical institution.)" However, Paragraphs 1905(a)(14) and (16) permit reimbursement for persons over 65 and under 21, respectively. Thus, Medicaid coverage is not available to otherwise-eligible patients between 21 and 65 who reside in state mental hospitals. Yet, there is no reimbursement prohibition for such persons if they are residents of private skilled nursing and intermediate care facilities (nursing homes).

The traditional rationale for the reimbursement prohibition for public facilities is that care of the mentally ill is a state, rather than a federal, responsibility. However, there are several reasons why this argument is not valid.

(1) *High Cost of Adequate Institutional Mental Health Care.*—States have chronically underfunded their mental hospitals to the point that only custodial care, rather than active treatment, has been provided. Even though the quality of care has increased dramatically in recent years, many patients still receive inadequate treatment because of the high cost of adequate mental health care.

According to the House Select Committee on Aging,<sup>2</sup> the national average cost per year per state hospital inpatient in 1977 was \$20,924. States, particularly those which are fiscally distressed, are hard pressed to pay the total cost of such programs. Yet private mental hospitals charge upward of \$50,000 per year per patient, demonstrating the high cost of intensive mental health treatment.

Medicaid-certified nursing home care is generally about as expensive as state hospital care. But, as demonstrated by the reports of the Senate Special Committee on Aging, the General Accounting Office and other federal and state agencies,<sup>3</sup> the quality of mental health care in nursing homes is often totally inadequate. Ironically, the federal government will pay at least 50 percent of the cost (depending on the state's federal medical assistance percentage) of nursing-home care for former mental patients, but will pay none of the cost of state hospital care for those between 21 and 65, no matter how adequate that care is. In other cases, patients who need continued mental health care are "dumped" into boarding homes and placed on Supplemental Security Income (SSI), which is 100 percent federally funded.

As the Senate Special Committee on Aging has noted, the "desire to save State dollars" through use of this illogical fiscal incentive is "clearly the most important reason" why States continue to "force" thousands of mental patients "out of State hospitals into nursing homes, boarding homes, old hotels—and sometimes into the streets."<sup>4</sup> The fiscal incentives are high—one mental health researcher estimates that New York State currently saves at least \$585 million per year because of the "deinstitutionalization" incentives.

(2) *Federal Intervention in State Mental Health Care.*—Recently a number of Federal courts have held that patients have a constitutional and statutory "right to treatment" and that States have not been providing such treatment. These decisions have mandated minimum standards for staffing levels, physical plants and the like, greatly increasing the costs of State Hospital care. (Apart from the minimum Medicaid standards for Intermediate Care Facilities, which are

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Footnotes at end of statement.

inadequately enforced.<sup>6</sup> Federal statutes and court decisions have seldom covered private nursing homes because they are not publicly operated.)

Several recently passed and pending pieces of Federal legislation provide for increased Federal involvement in institutional mental health care. For example, P.L. 94-63 requires States to submit plans to HEW for improving the quality of institutional care and to prescribe and provide for the enforcement of minimum standards for mental health facilities. HEW then provides special health revenue sharing monies to the State mental health authority. S. 1393/H.R. 9400, now in Conference Committee, provides for Justice Department intervention to protect the rights of patients in State institutions. S. 2410/H.R. 12460, also in Conference Committee, mandates additional State mental health planning activities.

Finally, because Medicaid will reimburse mental health care in private intermediate care facilities (such facilities account for the greatest share of total mental health care), the Federal Government is already deeply involved in reimbursing such care. The current fiscal incentives for private care strongly encourage the States to abdicate their responsibility to provide, and to pay for, adequate institutional mental health services.

*3. Unaccountable Private Facilities.*—The numerous Federal and State reports already described above have thoroughly documented widespread abuses of mental patients which have occurred in unaccountable private facilities, most of which are proprietary.<sup>7</sup> These facilities are legally accountable only to their boards of directors and stockholders. Consequently, they are concerned with profits rather than with adequate care.

Problems encountered in policing private facilities include inadequate licensing standards, insufficient appropriated funds to pay for Federal and State inspection staff, insufficient financial data on nursing home operations, the large number of facilities, restrictions on access to private property and the seller's market for care of this type.

*4. Congressional Recognition of Need to Reimburse Public Facilities.*—When Medicaid was enacted in 1965, reimbursement was made available to State mental hospitals for eligible recipients over 65 (Section 1905(a)(14) of the Social Security Act). In 1971, Congress added coverage for eligible persons under 21 in State mental hospitals (Section 1905(a)(16)) and for eligible persons who are residents of State retardation facilities which are certified as Intermediate Care Facilities for the Mentally Retarded (Section 1905(d)). These provisions show that Congress recognized the need for Federal cost-sharing in State institutional mental health care.

#### CONCLUSION

Federal reimbursement for *all* eligible state mental hospital patients is necessary both to provide adequate public care and to prevent abuses of patients by unaccountable private facilities.

#### RECOMMENDATIONS

1. Medicaid mental health coverage must be extended to all eligible patients in public mental institutions by repealing Section 1905(a)(17)(A) of the Social Security Act.
2. There must be strict public accountability and control over all facilities receiving Medicaid reimbursement for mental health services.
3. Congress should direct the HEW Inspector General to conduct special audits and investigations of any Medicaid facilities serving mental patients. Furthermore, as a condition to state participation in the Medicaid program, states should be required to conduct their own audits and onsite surprise surveys of Medicaid facilities for the mentally ill. Surprise surveys of all facilities should be conducted at least annually.

#### NOTES

1. *Senate Special Committee on Aging.*—In the series of reports entitled "Nursing Home Care in the United States: Failure in Public Policy," see especially "The Role of Nursing Homes in Caring for Discharged Mental Patients

(And the Birth of a For-Profit Boarding Home Industry), March 1976. The other reports in the Nursing Home series, including "Introductory Report," November 19, 1974; "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," December 17, 1974; "Drugs in Nursing Homes: Misuse, High Costs and Kickbacks," January 17, 1975; "Doctors in Nursing Homes: The Shunned Responsibility," March 3, 1975; "Nurses in Nursing Homes: The Heavy Burden (The Reliance on Untrained and Unlicensed Personnel)," April 24, 1975; "The Continuing Chronicle of Nursing Home Fires," August 30, 1975, document numerous abuses of ex-mental patients and other nursing home residents.

In addition, see "Kickbacks Among Medicaid Providers," June 30, 1977.

See also "Single Room Occupancy: A Need for National Concern" (Information Paper), June 1978, especially Appendix 4. While this paper directly addresses only Supplemental Security Income (SSI) coverage, it shows the problems which result when Medicaid coverage is not available to state hospital patients, leading to their "dumping" and then being placed on SSI rolls.

*House Select Committee on Aging.*—See "Pepper Charges 'Dumping' of Mental Patients Has Become a National Scandal," Committee press release, May 26, 1978. See also "The National Crisis in Adult Care Homes," (Hearings), Committee Publication 95-98, June 8, 1977, and "Adult Boarding Homes" (Hearings), Committee Publication 95-134, February 10, 1978.

*General Accounting Office.*—"Returning the Mentally Disabled to the Community: Government Needs to Do More," HRD-76-152, January 7, 1977; see especially Chapters 6 and 8.

See also the background reports on this issue for Massachusetts, Maryland, Michigan, Nebraska and Oregon.

*President's Commission on Mental Health.*—See "Report to the President" (Volume I), April 27, 1978, p. 22. See also the "Report of the Task Panel on Cost and Financing" (Volume II), pp. 503 and 525.

*HEW Inspector General.*—"Annual Report, April 1, 1977–December 31, 1977," March 31, 1978, pp. 78, 90, 140–142, 189.

*Assistant Surgeon General.*—Faye G. Addellah, "The Future of Long-Term Care," *Bulletin of the New York Academy of Medicine*, 54 (3), March 1978, pp. 261–270 (see especially p. 263).

#### STATE OFFICIALS

##### New York

Charles J. Hynes, Deputy Attorney General. "Private Proprietary Homes for Adults: Their Administration, Management, Control, Operation, Supervision, Funding and Quality—An Interim Investigative Report," March 31, 1977; also in House Select Committee on Aging, "The National Crisis in Adult Care Homes," *op. cit.*, Appendix 1. See also Appendixes 2 and 3.

##### Wisconsin

Martin J. Schreiber, Lieutenant Governor and Nursing Home Ombudsman, Series of Reports entitled "Accidental Mental Health Care—the Inappropriate Reliance on Nursing Homes"; Volume I: "Behavioral Patterns in Nursing Homes—No Available Alternatives," January 1977; Volume II: "Behavioral Modification Programs in Nursing Homes—Abusive Therapy," January 24, 1977; Volume III: "Behavioral Drug Therapy in Nursing Homes—A Pattern of Risk," March 13, 1977.

##### New Jersey

Statements of the following officials in House Select Committee on Aging, "Adult Boarding Homes," *op. cit.*: Stephen Parskie, State Senator, John Fay, former State Senator, William Gormley, State Assemblyman, David Wagner, State Deputy Health Commissioner, Ann Klein, Commissioner, State Department of Human Services, James Pennestri, Director, State Division of Aging.

##### Hawaii

Carl Takamura, State Representative, Testimony in Senate Select Committee on Aging, "The National Crisis in Adult Care Homes," *op. cit.*, pp 77–86.

##### Pennsylvania

Daniel Schulder, Special Assistant for Aging, Governor's Office, Testimony in House Select Committee on Aging, "The National Crisis in Adult Care Homes," pp. 28–55, 313–318.

2. "Pepper Charges 'Dumping,'" *op. cit.*, Table 4.

3. See Footnote 1.

4. "The Role of Nursing Homes in Caring for Discharged Mental Patients," *op. cit.*, p. 726.

5. Stephen Rose, "Deinstitutionalization—a Challenge to the Profession," paper presented at the Deinstitutionalization Institute, National Conference on Social Welfare, Los Angeles, May 1978.

6. See e.g., the series of Senate Special Committee on Aging reports, *op. cit.* and Abdellah, *op. cit.*

7. See Footnote 1.

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**NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS,**  
*Washington, D.C., August 29, 1978.*

Senator HERMAN TALMADGE  
Russell Senate Office Building,  
Washington, D.C.

DEAR SENATOR TALMADGE: While we, the National Association of Private Psychiatric Hospitals, were unable to testify at the hearings recently held by the Health Subcommittee on Medicare and Mental Health, we respectfully submit the following.

We hope that the information is helpful and that it clearly demonstrates the need to remedy many of the existing discriminatory practices within the Medicare system against the mentally ill.

We look forward to working with you and are available should any additional data be needed.

Cordially,

JOY MIDMAN, Associate Director.

**TESTIMONY SUBMITTED IN WRITING—MENTAL HEALTH CARE NEEDS IN MEDICARE**

Even though health insurance for the aged and disabled, Title XVIII, Medicare, was a commendable act of Congress, the needs of the mentally ill aged and disabled often go unmet. Furthermore, they are populations which find it difficult to ask for needed help and/or know where such help is available.

Psychiatric benefits under the Medicare program are limited at best and retroactively denied at worst.

The 190 lifetime inpatient limit and the restriction under Part B which limits annual outpatient coverage for mental illness to \$250.00, including ancillary services, represents a prime example of the restrictions.

The elderly today represent one in every ten persons. Within the next thirty years that number may well be more like one in every five. The elderly will not be served for several reasons. The elderly remain the group least likely to ask for help in general, and for medical, emotional, nervous, or mental problems in particular. Medicare does not pay for the treatment of emotional disorders on an equal basis with physical illness. Consequently, the alternative means of treatment are found all too often in the inappropriate placement of the elderly and disabled in nursing homes and/or intermediate care facilities. These facilities lack the personnel resources, dollars, and wherewithall to treat. (The President's Commission on Mental Health has recently stated that the nursing home population has risen by 113 percent. Sixty percent are said to have some emotional, nervous, or mental disorder.)

Several changes in the Medicare law are needed to rectify the discrimination. With the latest figures and studies demonstrating that with the adequate treatment of mental and emotional illness the expenditures of general health care dollars decreases; and with the latest figures demonstrating that 40 percent of the general health care dollars are now being spent on emotional, nervous, or mental disorders, such changes are more than indicated—they are needed.

The 50/50 copayment presently existing under the psychiatric benefit portion should be replaced with the standard 80/20 now utilized for physical illness. The elderly and disabled should not be forced to choose between physical or mental health care or food or housing needs.

The 190 day lifetime limit on inpatient benefits should be replaced with the standard definition of "spell of illness" utilized for the rest of medicine. If such a definition were to be applied, appropriate treatment, placement, screening, diagnoses, and aftercare programs could be followed. This would not only assure responsible spending, but in the long run save dollars, time, and people's lives.

The annual \$250.00 limit on outpatient psychiatric care should be eliminated. Greater utilization of outpatient psychiatric care would save dollars, encourage primary care and early intervention, and do away with the inappropriate utiliza-

tion of facilities. Many persons can be treated in an outpatient program which serves to be a less restrictive setting.

The estimated cost of correcting the inequities is guesstimated to be \$45 million. This does not take into account the great savings that would occur if inappropriate placements were to cease or the savings that would take place were persons able to receive appropriate treatment early on rather than forever.

The present policies under Medicare limit, if not disallow, partial hospitalization. Such a policy is regressive. At a time when outpatient and ambulatory programs are being developed and encouraged, and at a time when the government's program of deinstitutionalization is gaining national momentum, it would appear that coverage of partial hospitalization programs and services under Medicare would be a logical as well as excellent place to start. To fund a new program for renal dialysis, costing over \$100 million for a population of 40,000 persons, while ignoring the needs of what is now modestly estimated to be 15-20% of the population seems unfair and foolish; to say nothing of the fact that it ignores a major portion of the population.

Two bills have recently been introduced which would extend partial hospitalization benefits to Medicare recipients. However, both bills limit such care to qualified community mental health centers. Such a practice, if it should become operational, would fragment and already fragmented delivery system, favor but one provider, and serve a limited population.

A last bastion of discrimination under Medicare exists with the policies of allowing therapeutic leave days are encouraged to be utilized by patients in skilled nursing facilities and intermediate care facilities. They are disallowed when utilized by free-standing psychiatric hospitals. The irony of this policy, be it administrative or regulatory, lies in the fact that it is within the psychiatric hospital that such leave days are medically necessary, part of a therapeutic program, and even mandated by law. Public Law 92-603, the Social Security Amendments of 1972, require utilization review of Medicare and Medicaid patients within all facilities. Appropriate utilization review means concurrent review of all patients' care. This means monitoring levels of care, requests for extended care, on-going review and discharge planning. In planning an appropriate discharge to avoid remission and assure recovery therapeutic leave days provide the patient with the chance to return to his/her home environment or community placement to evaluate the success of such a program. To deny such care is to negate quality care and negate the standards of the Joint Commission on Accreditation of Hospitals which deal with the programmatic elements of care.

The National Association of Private Psychiatric Hospitals represents over 170 free-standing psychiatric hospitals. All are accredited by the Accreditation Council of Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals. Our membership includes community health centers, residential treatment centers for children, units of general hospitals (over 100 beds in size and accredited separately by the ACPF/JCAH), and university affiliated hospitals. They are both non-profit and proprietary in corporate structure. All provide a wide range of treatment modalities and philosophies.

What must be stressed is that the free-standing psychiatric hospital is often half the cost of care rendered in a psychiatric unit of a general hospital. Unlike free-standing psychiatric hospitals, psychiatric units in general hospitals are often glossed over in terms of standards and programs, while the free-standing psychiatric hospital is accredited for each and every program provided. It has never seemed fair that the psychiatric unit is the favored setting in reimbursement policies when more often than not it is the less intense, less comprehensive, more expensively modality of care.

We hope that with the findings of the President's Commission on Mental Health, Congress will find it easier to remedy existing discriminatory practices which for too long have interferred with the abilities to delivery quality comprehensive care to those most in need.

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MENTAL HEALTH ASSOCIATION,  
Arlington, Va., August 10, 1978.

Hon. HERMAN E. TALMADGE,  
*Chairman, Subcommittee on Health, Senate Finance Committee, Dirksen Senate Office Building, Washington, D.C.*

DEAR SENATOR TALMADGE: The Mental Health Association and its 850 affiliates ask that you support the removal of the following discriminatory language on page 3 of S. 1392 on the Child Health Assessment Act (CHAP): "... but not

necessarily for the treatment of mental illness, mental retardation, or developmental disabilities." This position is in concurrence with the recommendations of the President's Commission on Mental Health Report that states: "The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program of Title XIX (Medicaid) of the Social Security Act does not include the availability of treatment and service provisions to cover mental illness, mental retardation, and developmental disability when these conditions are diagnosed. The proposed Child Health Assessment Program should mandate that these services be available. As a general rule, a dollar for follow-up services should be allocated for every dollar allocated for screening."

Apparently, one of the reasons why mentally ill children were not covered in this legislation was the fear that it would add greatly to the overall costs of the EPSDT Program. While data is limited related to the cost of inclusion of children in this particular legislation, there is extensive information regarding the reduction of physical health care costs, when mental health services are available in health plans. Enclosed is "Coverage of Mental Health in National Health Insurance Can Be Cost Effective," which documents that point. Following are brief excerpts:

(a) Under the California Psychological Health Plan there was a decrease of 27% in medical care utilization after mental health benefits were included in the Plan. (page 4)

(b) Nicholas Cummings, a well known mental health researcher, states, "We have found not only that psychotherapy can be economically included as a pre-paid insurance benefit, but also that failure to provide such a benefit jeopardizes the effective functioning of the basic medical services, since 60% or more of the physician visits are made by patients who demonstrate an emotional, rather than an organic, etiology for their physical symptoms." (page 5)

(c) Blue Cross of Western Pennsylvania reports that "overall medical/surgical utilization is reduced for that subgroup of subscribers who use the outpatient psychotherapy benefit. Further, this phenomenon of reduced medical/surgical utilization with exposure to outpatient psychotherapy was found to be independent of age, sex, or employment level (salary versus hourly employee groups). The study findings are consistent with the results of two previous studies . . ." (page 2)

(d) The Kennecott Copper Corporation has estimated a return of \$5.83 per \$1.00 cost per year for its psychotherapy program. Impact is noted in reduced absenteeism, reduced hospital, medical and surgical costs, and reduced costs of non-occupational accident and illness." (page 2)

We believe the foregoing reasons provide persuasive evidence that removal of the discriminatory language in S. 1392 is fiscally sound, in addition to being right. For additional information on our CHAP position, we have included our testimony before the House Subcommittee on Health and the Environment on September 9, 1977. We ask that this be included as part of the record for the hearing.

If we are truly dedicated to improving mental health, how can we ignore the goal of improved mental health for children, on whom the nation must rely in the future?

Sincerely,

ALLAN MOLTZEN,

*National Chair, Committee on Legislation and Services.*

Enclosures.

#### STATEMENT OF JULIA OLIVER FOR THE MENTAL HEALTH ASSOCIATION

Mr. Chairman and Members of the Subcommittee: My name is Julia Oliver and I reside in Tallapoosa County, Alabama. I am appearing today in behalf of the Mental Health Association of which I am a member of the Board of Directors and on the Committee on Legislation and Services. In addition, I am a social worker who has worked in Bryce Mental Hospital. I am the former Commissioner of Public Welfare in Alabama and am now an administrator in the Department of Pensions and Security and I am familiar with the administration of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT).

The Mental Health Association is the national citizens' voluntary organization, with membership approaching one million, representing consumers of mental health services. Our goals are to work for improved methods in the research, prevention, detection, diagnosis and treatment of mental illness, as well as the promotion of good mental health.

Mr. Chairman, we are very grateful for this opportunity to present our views to the Subcommittee on Health and the Environment.

The Mental Health Association believes that it is just as important for CHAP to provide treatment for the mentally ill as for the physically ill. We, therefore, urge the House Subcommittee on Health and Environment to delete the discriminatory and inequitable language in H.R. 6706 that states: "... but not necessarily including those for the treatment of mental illness, mental retardation, or developmental disabilities". This language is contained on page 3, Section 3, subparagraph G, lines 9, 10, and 11 of the Child Health Assessment Act (CHAP).

The Mental Health Association has consistently been an advocate for improved programs and services for mentally ill children. The Association believes that a total system of care must be available for children suffering from mental illness, and treatment programs for children from all income levels are essential. The CHAP proposal clearly discriminates against low income mentally ill children and will be another barrier to equal opportunity for treatment.

Unless CHAP mandates the treatment services for the mentally ill, many children will be deprived of these necessary and important services. This discrimination would compound an existing practice whereby the Medicaid program has consistently and arbitrarily discriminated against one segment of the population—the mentally ill people: only 29 states, as of June 1, 1976, were providing the Medicaid *option* to cover care for patients under twenty-one in psychiatric hospitals. And not all states provide outpatient care.

To mandate the screening and diagnosis of eligible children and then not make provisions for the recommended treatment seems inconsistent with the goals of H.R. 6706. Those stated goals are to strengthen and improve the EPSDT program for children whose families do not have adequate resources to cover the cost of such care and to provide further incentives to States to arrange for—and encourage—quality health care for children. Authorizing treatment for physical, but not for mental illness is rather like saying that under CHAP children can be treated from the neck down but not from the neck up. Why is it necessary to make this unfair, arbitrary distinction?

Gentlemen, one example of the value of early diagnosis and treatment is the story of a child with whom we have had a personal experience. He, tragically, did not come to the attention of authorities until he was twelve years of age. All of his life he exhibited behavioral problems. Because of his acting out behavior, his mother was unable to cope. She placed him in foster care and immediately deserted. His father refused to accept responsibility for his son's behavior. Although some treatment was given while in foster care, this was shortlived. His behavior finally culminated in expulsion from school, and he eventually went on the streets—drugs led to institutionalization and later his criminal behavior resulted in being imprisoned. Perhaps early diagnosis and treatment would have helped this boy and he would have been an asset, instead of a liability, to society.

Mental illness affects at least 10% of our population, including children and youth, and it has been said by the American Medical Association to be the country's No. 1 health problem. Yet there still remains discrimination, inadequate financial support, and stigma for those who suffer from mental illness. Partially because of recent successful court cases of litigation, especially in right to treatment cases, and legislation, such as the Education for All Handicapped Children Act (P.L. 94-142), the historical neglect of mentally ill persons is changing. Surely treatment services for the mentally ill children should be included in such an important health program as envisaged in H.R. 6706.

The incidence of mental illness is increasing, and services that focus on prevention, early detection, and treatment are essential. Children who are mentally ill are grossly underserved. In a 1976 U.S. Office of Education report, it was estimated that 55% of the nation's 7.8 million handicapped children are served by educational programs. The emotionally disturbed children were the most unserved; only 13% of those suffering such handicaps were served! The CHAP proposal is continuing to view mentally ill children as ones who will be served only after the needs of others are met. Delay in treatment compounds the problems of the mentally ill child and increases the chances that long term, expensive hospitalization will be necessary for them. In addition, treatment for emotional problems is interrelated with physical health. Some studies, including the 1975 California Psychological Health Plan, have shown lower costs for the treatment of physical illness when adequate mental health services are available. According to Kaiser-Permanente and other studies, more than half the complaints in doctor visits have a significant psychological basis or component.

It seems logical and cost effective to invest in services that focus on prevention, early detection, and treatment for high risk children. These services could help increase future earning capability, prevent institutionalization, and prevent chronic dependency. The CHAP program has potential for being an important means of prevention. The treatment services could prevent the problems from being compounded and made more complex. These services could help a child develop to his/her maximum potential.

By not mandating coverage of critically needed treatment services, progress will be further delayed in meeting the needs of children whose mental and physical health is adversely affected due to the effects of poverty. The Joint Commission on the Mental Health of Children in 1969 listed some facts that indicated a need for priority attention to physical and mental health needs of poor children. These facts included:

"Analysis of Head Start children showed that at least 10% were judged to be crippled in their emotional development by the age of four years. In some cities, this figure is estimated at 20 to 25%."

"The early results of a current study of mental and emotional disorders among children in Manhattan show that rates are much higher for poor children and for children who are members of oppressed minority groups."

Treatment of mentally ill children is not more expensive than many of the conditions covered in CHAP. In 1973 Blue Cross-Blue Shield Federal, High Option had only 2.7% of its admissions for mental conditions for patients under 18 years of age. Without adequate diagnosis and treatment, the costs of mental illness to society are great, because the highest proportion of the cost is due to decreased productivity because of mental illness—not treatment costs. Of the <sup>1</sup> \$37 billion estimated costs, \$14½ billion is for direct care, and \$19 billion is because of decreased productivity and related indirect costs. All of which could have been decreased if services had been available to individuals at an earlier age.

The CHAP proposal will not resolve the serious lack of programs serving the children who have—or could—potentially have emotional problems. The actions taken regarding the treatment of mental illness in this Legislation could have a major impact on how National Health Insurance proposals are drafted. In addition, Community Mental Health Centers cannot continue to serve children and youth unless other Federal programs such as CHAP become part of the base of continued financial support created by the Federal seed money for these centers.

Mr. Chairman, with the current wording of the Legislation, the rights and priorities of the mentally ill, mentally retarded, and developmentally disabled continue to be neglected. The Mental Health Association believes that this capricious and arbitrary discrimination against low income mentally ill children can—and should—be eliminated by striking lines 9, 10, and 11 of Section 3, subparagraph G of H.R. 6706. Under the provisions as they now exist, there is a possibility that some states would label children—mentally ill, developmentally disabled, or mentally retarded—as a means of avoiding providing otherwise mandated services. You are able to remove the obstacles put forth in the legislation and allow all of these children to have an equal opportunity to receive assistance in overcoming their handicaps at an early stage in their growth and development. We thus urge you not to allow these children to go without treatment and that you mandate this treatment for mentally ill, as well as physically ill, children. Without prevention and treatment the costs are high—in terms of human life, usefulness to society—and in extremely high fiscal costs.

Mr. Chairman, some children who are mentally ill will either be relieved from their pain or their suffering will continue. Their fate rests largely in your hands and the action by this Committee.

Thank you for the opportunity of presenting the views of the Mental Health Association.

#### COVERAGE OF MENTAL HEALTH IN NATIONAL HEALTH INSURANCE CAN BE COST EFFECTIVE

Early studies, such as Goldberg, Krantz and Locke's, conducted in 1965, have located a significant factor in the cost of comprehensive health coverage.

The results of their pilot study clearly indicate that, "the short-term outpatient psychiatric benefit at G.H.A. (Group Health Association) was associated with a decrease in the utilization of physician and ancillary services under the plan.

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<sup>1</sup> NIMH, 10/75, Division of Biometry and Epidemiology.

Not only was there a decreased utilization following psychiatric referral for the study group as a whole, both with respect to the number of persons seen and the number of visits made, but this decreased utilization held—to a greater or lesser degree—for all subsegments of the population studied. . . . There was no attempt to do any cost-benefit analysis in this study, the primary purpose of which was directed at utilization without regard to costs. However, an inference could be made that the cost savings due to reduced utilization would be reflected in the entire benefit structure without setting forth dollar amounts.<sup>1</sup>

Other studies at Kaiser-Permanente<sup>2</sup>, and at the Department of Research and Statistics, Health Insurance Plan of Greater New York<sup>3</sup> strengthen the hypothesis that reduced utilization of medical services is a result of short-term outpatient mental health benefits, in prepaid health plan settings.

Mary Ellen Olbrisch, in "American Psychologist"<sup>4</sup> has prepared an overview of the literature on the effects of psychotherapeutic treatment on physical health. She says, "A question of central importance in policy decisions regarding national health insurance is whether it will be economically feasible to cover the cost of psychotherapy." In reporting the effects of psychotherapeutic programs on alcohol abuse, she notes that, "Persons with alcohol problems constitute a group whose medical costs are very high. In addition to their high utilization of medical services, these individuals cost their employers a great deal in absenteeism and lost production. Some interesting research has been conducted which suggests that active intervention programs not only reduce medical care utilization by troubled persons, but actually result in a profit to the employer funding the intervention program."

The Kennecott Copper Corporation has estimated a return of "\$5.83 per \$1.00 cost per year for its psychotherapy program. Impact is noted in reduced absenteeism, reduced hospital, medical and surgical costs, and reduced costs of non-occupational accident and illness."<sup>45</sup>

More recently, December 1976, a study sponsored by Blue Cross of Western Pennsylvania reports that "overall medical/surgical utilization is reduced for that subgroup of subscribers who use the outpatient psychotherapy benefit. Further, this phenomenon of reduced medical/surgical utilization with exposure to outpatient psychotherapy was found to be independent of age, sex, or employment level (salary versus hourly employee groups). The study findings are consistent with the results of two previous studies. . . ."<sup>6</sup>

The Western Pennsylvania study estimates the resultant cost savings relative to the cost of providing the benefit. "Since 1958, this population has had access to outpatient psychotherapy services through a community mental health clinic. However, Blue Cross coverage for these services did not become available until January, 1968.

The outpatient coverage provided for this population includes only those services obtained through the local mental hygiene clinic or a similar "approved comprehensive community mental health center." The outpatient services covered included:

1. Group therapy up to 50 sessions during any 12 month period;
2. Collateral visits with members of the patient's family;
3. Professional services up to 50 visits during any 12 month period;
4. Psychoactive drugs.

Inpatient coverage, which was not limited to the clinic, provided for up to 90 days of inpatient care per year.

Emphasis was on early referral and short-term intensive therapy. Services of all mental health disciplines were covered, including those of psychiatrists,

<sup>1</sup> Group Health Association, GHA News—Annual Report Issue, vol. 28, No. 1, March 1965.

Group Health Association, GHA News—Annual Report Issue, vol. 30, No. 2, March 1967.

<sup>2</sup> Follette, W., and Cummings, N. A.; Psychiatric services and medical utilization in a prepaid health plan setting, Medical Care 5:25, 1967.

<sup>3</sup> Department of Research and Statistics, Health Insurance Plan of Greater New York. Psychiatric Treatment and Patterns of Medical Care, Unpublished final report to the National Institute of Mental Health, Project MH 02321, July 1969.

<sup>4</sup> Olbrisch, Mary Ellen, Psychotherapeutic Interventions in Physical Health, American Psychologist, Sept. 1977.

<sup>5</sup> Kennecott Copper Corporation, Insight, Unpublished report, Utah Copper Division, Salt Lake City, 1975.

<sup>6</sup> Jameson, J., Shuman, L. J., Young, W. W. The Effect of Outpatient Psychiatric Utilization on the Costs of Providing Third-Party Coverage, Research Series 18, Blue Cross of Western Pennsylvania.

clinical psychologists, psychiatric social workers and psychiatric nurses. The first 15 visits for any of these services were covered in full. Thereafter the subscriber was required to make a co-payment of one-third of the cost of covered services. The coverage was designed to discourage long-term psychotherapy by stipulating that any treatment given more than 15 days following the date of the first covered service would be covered only if a psychiatrist certified that continuing treatment was required. Thereafter, this certification had to be renewed every 30 days.

These benefits closely resemble those advocated by the Mental Health Association for inclusion in National Health Insurance.

Findings of the study report that "The average adult total monthly costs after initiating outpatient psychotherapy are \$8.52 less than they were before first outpatient psychiatric contact (even with the cost of that therapy included). . . ."

FIGURE 1

**COMPARISON OF ADULT MALES AND ADULT FEMALES—MONTHLY AVERAGE OF UTILIZATION BEFORE AND AFTER FIRST OUTPATIENT PSYCHIATRIC CONTACT**

	N	Medical-surgical				Psychiatric				Total, cost per patient per month
		Average exposure months	Inpatient days per month	Out- patient visits per month	Cost per patient per month	Inpatient days per month	Out- patient visits per month	Cost per patient per month		
<b>Adult males:</b>										
Precontact.....	24	21.74	0.198	0.139	\$21.00	0.157	-----	\$6.72	-----	\$27.72
Pst-contact.....	27	24.15	.077	.015	5.28	.154	0.175	11.21	-----	16.49
<b>Adult females:</b>										
Precontact.....	43	22.95	.189	.044	13.22	.205	-----	7.72	-----	20.94
Post-contact.....	50	27.23	.096	.025	8.83	.043	.491	5.95	-----	14.78
<b>Increase or decrease:</b>										
Adult males.....		(.121)	(.125)	(15.72)	.003	.715	4.49	(11.23)	-----	(11.23)
Adult females.....		(.094)	(.019)	(4.39)	(.162)	.491	(1.77)	(6.16)	-----	(6.16)
<b>Ratio—Post/pre:</b>										
Adult males.....		.389	.107	.251	.980	-----	1.669	.595	-----	.595
Adult females.....		.505	.575	.688	.210	-----	.771	.706	-----	.706

Figure 1 compares the pre-contact and post-contact experience of adult males with that of adult females. "Of particular interest is the indication that adult males have the highest pre-contact use of medical services of any sub-group in the sample (costs of \$21.00 per month), the greatest post-contact reduction in use of these services (\$15.72), and the greatest reduction (\$11.23) in total cost per month after initiating outpatient psychotherapy."

The California Psychological Health Plan, a statewide, prepaid mental health plan offered by a public carrier, entitles eligible subscribers, and their dependents (for a cost of \$4.00 per family, per month), to obtain benefits from any member of a panel of 200 contracted providers located throughout the State.

The plan is based on the concept that the consumer has the responsibility for his/her own mental health and its maintenance through utilization of insured mental health benefits. The California Psychological Health Plan emphasizes education of the consumer about mental health needs, and early intervention. It offers incentives through a system of total confidentiality, no deductible, no co-payment for the first five visits, quality control and the elimination of claim forms.

The C.P.H.P. was first placed in a small health and welfare trust of 1,000 employees and their families. The trust had been insured for five years prior to the integration of C.P.H.P. in the benefit program. In the years prior to the institution of the C.P.H.P. (11-74 to 8-75), 95 percent of the total paid premium was paid out by the company for medical claims. In the year following (12-75 to 9-76), 73.5 percent of the premium was paid out for medical claims. Within one and one-half years, the "loss ratio" had decreased to 67 percent. These figures represent an approximate decrease of 27 percent medical care utilization costs.

The only component in the trust which changed, over this period, was the mental health benefit.<sup>7</sup>

<sup>7</sup> California Psychological Health Plan, 4401 Wilshire Blvd., Los Angeles, CA 90010.

Research findings continue to show the relationship between appropriate mental health coverage and reduction of cost of physical health coverage. Nicholas Cummings, reflecting on his studies now in press, says, "We have found not only that psychotherapy can be economically included as a prepaid insurance benefit, but also that failure to provide such a benefit jeopardizes the effective functioning of the basic medical services, since 60 percent or more of the physician visits are made by patients who demonstrate an emotional, rather than an organic, etiology for their physical symptoms."<sup>8</sup>

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<sup>8</sup> Cummings, N. A., *The Anatomy of Psychotherapy Under National Health Insurance*, American Psychologist, Sept. 1977.











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